An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 071

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Smyly Trust**
Registered Capacity:	**4 young people**
Type of Inspection:	**Announced themed inspection**
Date of inspection:	**7th and 8th of January 2020**
Registration Status:	**Registered without attached conditions from 30th April 2020 to 30th April 2023**
Inspection Team:	**Linda Mc Guinness and Eileen Woods**
Date Report Issued:	**10th March 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 their first registration in 2002. At the time of this inspection the centre were in their sixth registration and were in year three of the cycle. The centre was registered without attached conditions from 30th April 2020 to 30th April 2023.

The centre was registered to provide medium to long term care for up to five young people of both genders from age twelve to seventeen years on admission. Their model of care was described as providing residential child care for young people using a therapeutic community approach to meet their emotional and developmental needs within a caring and stable structure. The model was based on five principles of attachment, containment, communication, citizenship and reflection. The goals were to be attained through individual work, group work, and family involvement.

There were three young people living in the centre at the time of this 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, centre manager on the 22/01/2020 and to the relevant social work departments on the 22/01/2020. 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 the05/02/20. This 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: 071 without attached conditions from the 30th April 2017 to 30th April 2020 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

At the time of inspection work had commenced and was well underway to review all policies and procedures to ensure that they were brought in line with the National Standards for Children's Residential Centres, 2018 (HIQA). Working groups had been established for this purpose which had representatives of staff teams and management. The final policies were to be signed off by the board of management and any required training to be provided to staff following completion.

All staff had received training in the Tusla E-Learning module: Introduction to Children First. Most staff had received supplementary training in respect of Children First: National Guidance for the Protection and Welfare of Children, 2017. However, the recently appointed manager has yet to complete this training and this must be prioritised. Staff members interviewed were fully able describe all their roles, responsibilities and reporting procedures under legislation. Staff members interviewed were familiar with the child safeguarding statement (CSS) which was

displayed and had been approved by the Tusla Child Safeguarding Statement Compliance Unit.

The organisation had a policy in respect of protected disclosures which outlined the principles, process and supports available to a person making a report under the policy. The manager felt that initially staff would not be comfortable challenging each other's practice however having completed work with them regarding their obligations they felt that this had improved. Staff members interviewed during the inspection were confident that poor practice among staff would be reported appropriately and taken seriously.

Staff recruitment was part of the child safeguarding process however, inspectors noted that if issues arose during the Garda vetting process that there was no corresponding risk assessment or definitive process to follow. This should be included in recruitment policies and procedures.

There was a policy in respect of bullying and harassment which was connected to the centre's child protection policies. The policy included, training for staff and maintaining a culture whereby young people and the staff team were encouraged to disclose and discuss incidents of bullying. It also required monitoring incidents on an on-going basis. Inspectors found where issues of bullying arose individual work and community meetings took place to ensure any negative impact was minimised. Each young person had a number of plans in place to address individual needs and to identify areas of risk. Young people were supported through keyworking, community meetings and social skills groups to develop skills for personal protection and self - care. Inspectors found that there appeared to be a heavy focus on only keyworkers completing tasks and providing information to, and about young people. This was also noted in feedback from social work teams to the lead inspector and was a finding in the last inspection process. The centre manager must ensure that all staff are responsible for implementation of young people's plans and appropriate communication to relevant people.

Feedback to inspectors from young people indicated that they would speak up and seek help if they felt unsafe. Social workers confirmed that they were satisfied that the centre had appropriate measures in place to keep young people safe and programmes to teach them life skills.

There were measures in place through joint working with social work departments to ensure parents would be made aware of any allegation of abuse. There was evidence

that the management and team worked in collaboration with families and relevant professionals although social workers felt that communication could be improved.

Standard 3.2

In line with the stated evidence based model of care there was a focus on positive behaviour management with each person having responsibilities to others in the community. Policies and procedures took human rights, legislation and regulations into consideration. Young people were helped to understand the possible impact of their behaviour on others.

The centre had a policy in respect of behaviour management which had a focus on considering the possible underlying causes of challenging behaviour. Social work teams provided sufficient information to facilitate robust behaviour management planning. Specialist support was provided to the staff team by the consultant child and adolescent psychologist however this guidance could be better evidenced on young people's plans.

One inspector attended a team meeting and it was clear that there were reflective discussions about behaviour management. The use of negative consequences was minimal and the team sought instead to focus on restorative actions, repairing relationships and the use of natural consequences and resolution through community meetings. One inspector attended a handover meeting and found that the staff team had the required skills and knowledge and there was a child focused analysis of behaviour. There was evidence from observations and review of records that the team were able to pick up on signs of trauma in young people and respond to non-verbal cues.

Staff had been trained in a recognised model of behaviour management and refresher training took place within the required timeframes. Supplementary training was provided in support of individual care needs of young people when the need arose in line with a comprehensive staff training policy.

Individual behaviour, crisis and absence management plans were in place for each young person and were updated as required and sent to supervising social workers for approval. While there was good guidance for staff in these plans the content and language of some could be seen as subjective and judgemental. This issue was also raised during the last inspection and must be addressed as a matter of priority. Inspectors recommend that the social care manager reviews the content and language

of these plans to ensure that they could be accessible and understood by young people as supporting them. The team were aware about the impact of mental health and bullying on young people.

A restrictive practice policy had been recently devised which was to be signed off and communicated to the individual teams in the organisation in the weeks following inspection. There was a capacity to have alarms on young people's bedroom doors as a safeguarding measure but this was risk assessed as not required at the time of inspection. There were no other restrictive practices in place in the centre. There was some confusion as to whether there was a policy against the use of restraint or physical interventions. The policy indicated that the staff were trained and that it could be used as a last resort if required to keep people safe, however, a number of people including the manager spoke about a no restraint policy. The individual crisis management plans did not specifically state what interventions could be used or if they were contra-indicated. This must be revised by centre management and clarity provided to all staff in line with the stated recognised model of behaviour management. Young people and parents should also be made aware through centre information booklets that restrictive practices may be required on occasion to ensure safety.

Sanctions, rewards and behaviour management were all subject to review through a quality assurance process of internal audits. There was not adequate evidence at the time of inspection that there was a formal auditing/robust analysis of behaviour management by the director of service to provide external oversight and direction. Support and debriefing was available to staff members if required. There was a system in place whereby the therapeutic model was audited by an oversight body.

Standard 3.3

The model of care was based on therapeutic community whereby people were encouraged to raise concerns and report incidents. This was evident at a local level through community meetings which could be called by staff members or young people.

The organisation had a policy in respect of complaints which was revised following the previous inspection. This policy reflected the content of the Tusla Tell us complaints policy and it was evident that young people and staff members understood how it was implemented in practice. At the time of inspection 'level 1 complaints' under the policy were generally dealt with informally on an individual basis or at community meetings and were recorded in daily log books or meeting

records. Inspectors recommend that these are more formally recorded to facilitate auditing and effective tracking.

There was a policy in respect of the notification, management and review of significant events. They were reviewed on a monthly basis at the significant event review group (SERG) between two centres within the organisation. The analysis included how the report was written, and if the incident was managed effectively. There was evidence that learning was communicated to the staff team. It is recommended that implementation of agreed approaches in the individual crisis management plan are analysed at SERG as required by the model of behaviour management in use. Incidents were also analysed for trends up or downwards on a database which was included in the annual report for the service. Management, staff and clinical professionals participated in these review meetings and learning was communicated back to relevant staff teams. The social workers for young people informed inspectors they were generally satisfied with the prompt notification of significant events and they were included when updates to young people's plans were required following review of an incident.

The organisation compiled an annual report however there was no mechanism yet place to receive formal feedback from parents or significant others and this should be built into the annual report and service improvement plans.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The director of service must ensure that all staff including management have received adequate training in Children First: National Guidance for the Protection and Welfare of Children, 2017.

- The centre manager must ensure oversight of young people's plans to ensure the content and language is appropriate and that recommendations of specialists are evidenced and actioned.
- The centre manager must ensure that there are appropriate mechanisms in place to ensure that young people do not have to wait for availability of keyworkers information or completion of required tasks.
- The director of care and centre manager must ensure that clarity is provided to all staff and all relevant people in respect of restrictive practices including physical intervention.
- The director of care and centre manager must ensure that notification, auditing, tracking and conclusion of complaints is in line with national standards.
- The director of care must ensure that there is internal and external auditing of approaches to behaviour management.
- The director of care must ensure that there are mechanisms in place to receive formal feedback from parents and significant others and include this in service improvement plans.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

Inspectors found that the organisation had initiated a review of policies and procedures to bring them in line with revised National Standard for Children's Residential Centres, 2018 (HIQA). This process should be brought to a conclusion and any required training provided to the staff teams to ensure full implementation in practice. The centre manager had recently facilitated a workshop at the team meeting to map the new standards to the model of care and this was reported to have been a useful exercise.

The centre had undergone a period of significant change and team morale was low. Inspectors found that reflection and support through supervision should have been an absolute priority, however supervisions were not occurring or being recorded as set out in centre policy for management or staff. This should have been addressed by the external manager for the service as part of robust governance. This was an action required from the last inspection of this service and as such, is not yet implemented as required.

In general, staff members communicated to inspectors through interviews and questionnaires a good understanding of the model of care, legislation, policies and procedures which informed their work however there was some evidence of resistance to change and low morale was noted throughout the inspections process.

Standard 5.2

There was a management structure in place relevant to the size of the organisation however there was some confusion as to lines of authority and accountability within the centre. There was a social care manager, recently appointed deputy, three social care leaders and five fulltime equivalent social care worker posts.

Inspectors found that in some cases there was not clarity in relation to roles or responsibilities. A social care worker had recently been appointed to the role of deputy social care manager but that this was an expression of interest and was not remunerated as such. The person appointed had no job description and there was lack of clarity as to whether this was a full time role as they were scheduled to work three days from 9am to 5pm and work a sleepover shift for the remainder of their hours. Neither they nor the staff team were clearly able to describe the role and seemed to think they were only in a management capacity on their day shifts.

There was a service level agreement in place with Tusla, Child and Family Agency however the organisation was still in negotiations in respect of adequate funding for the deputy social care manager role and centre staffing. The annual report which was sent to the funding body did not include compliance with regulations and national standards and this must be included. At the time of inspection one social work department was providing extra funding to ensure that there was triple cover on shifts. This was related to risk and was unlikely to be continued in the long term as this had substantially decreased. If this extra staff member was not available there would not be adequate staffing to ensure safe and effective care in line with the model of care and needs of young people. The director of care informed inspectors that the issues relating to the deputy manager should be resolved through negotiations with Tusla relating to compliance with the Working Time Directive but there was no definitive timeframe on this.

A qualified centre manager who had experience in therapeutic communities and disability services in residential care had been in post for six months at the time of inspection. There was evidence that they had a focus on compliance with regulations and standards and implementation of policies and procedures.

One young person interviewed knew who was in charge and were happy with how the centre was being managed. There were not yet clear arrangements in place to provide adequate managerial cover when the manager took periods of leave and this must be determined as a matter of priority. There was not yet a log as required for recording where managerial responsibilities were to be delegated to another person.

There was a system in place for review and updates of policies and procedures and staff members contributed to this process in team meetings and through specific working groups.

A new risk management system was in place to support the identification, assessment and management of risk within the centre. There was a matrix which scored and considered measures to reduce risk. Staff members were to be trained in its application in the weeks after inspection.

Standard 5.3

There was a publically available statement of purpose and function however there was no date as to when this had been reviewed and this is recommended as part of good governance. There was evidence that that staff understood the purpose and function of the service and that it reflected the day-to-day operation of the centre. A version of the purpose and function was available for young people and their families. It described the staffing complement, community meetings, keyworking supports, rights and responsibilities, complaints, education, consequences, and access to information amongst others. The young person's booklet was being revised at the time of inspection with input from the current group living in the centre. The revised document should include more information in respect of keeping young people safe to include the possibility of the use of restrictive practices such as physical interventions, room searches or alarms for example.

Standard 5.4

There were some internal systems in place to assess on an on-going basis the quality of care provision, to analyse staff practice and review outcomes for young people. These included management reports to the director of service, staff audits of files and visits by the director to the centre to quality assure centre records. Team meetings took place on a weekly basis and were generally well attended. Meetings reviewed covered updates for young people, any safeguarding concerns, health and safety, policy review and GDPR. Issues arising from community meetings were also

considered at this forum. The director of service indicated that they had attended a number of these meetings however this was only evident on one of the records of the meetings reviewed during inspection. Centre management must ensure that the attendance and contribution of the director is recorded appropriately in minutes of team meetings. In general, the discussion in meetings was not recorded in adequate detail, nor was there a proper record of decisions taken and actions agreed and this must be addressed by the centre manager and monitored by line management.

There was a code of governance and database to facilitate compliance with corporate obligations. The director of service provided monthly reports to the board of management. Bi annual audits were completed by centre management however these had a strong focus on check lists as opposed to a thorough review of the quality of care provision and adherence to policies.

Some issues which arose during the inspection process had not been identified through external auditing as required by national standards. While the above mentioned quality assurance mechanisms were in place, inspectors found that the compliance audits were internal and reported out to the director of service. They were not yet specifically assessing and benchmarking against the National Standard for Children's Residential Centres, 2018 (HIQA). The quality assurance system should be revised to ensure that there is external auditing of compliance with standard and regulations as opposed to only a quality assurance of internal audits. Specific action plans with formal follow up must be created to address any deficits in compliance.
Management meetings took place monthly and were attended by the social care managers, deputy manager (if in place) and the director of service. Inspectors reviewed a sample of records which included planning for young people, staffing and HR issues, health and safety, supervision, therapeutic task, child protection, strategic governance plan, clinical support and policy review amongst others. Inspectors found that there was a lack of detail relating to the discussions and decisions across these meetings and this should be addressed.

The CAPA completed in response to an inspection in January 2019 indicated that improvements were required to auditing processes and adherence to supervision policy amongst others. These actions were still outstanding at the time of inspection and the director of care must ensure full implementation of inspection recommendations with on-going review.

There was a report prepared annually which included; an overview of each service; trends relating to incidents; safeguarding statements; social skills programme, staff support; general updates and financial statements amongst others. It did not specifically address compliance issues nor were there an associated service improvement plan arising from the annual review and this is recommended.

All social workers interviewed during the inspection process were happy with the quality, safety and continuity of care being provided to their young person.

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 5.1**
Practices met the required standard in some respects only	**Standard 5.2** **Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The director of care must ensure that their audit framework is benchmarking policy and practice against regulations and the National Standards for Children's Residential Centres, 2018 (HIQA). Specific action plans with formal follow up must be created to address any deficits in compliance.
- The director of service must ensure that all issues including those relating to supervision, staffing, records and governance as outlined in this report are addressed as a matter of priority.
- The director of care must ensure that there is clear direction on who acts up while the manager takes periods of leave
- The director of care must ensure that there is clarity regarding the position and role of deputy social care manager and their responsibilities
- The director of care and social care manager must ensure that there is a log for delegation of duties by the manager to deputy and social care leaders
- The director of care must ensure that there is a review date for the purpose and function and policies procedures

- The director of care must ensure full implementation of inspection recommendations with on-going review through auditing processes.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director of service must ensure that all staff including management have received adequate training in Children First: National Guidance for the Protection and Welfare of Children, 2017.	Centre manager and relief staff have attended this training. This was completed 21st Jan 2020 all staff now hold this training.	The director of service will have oversight of the following: Recruitment process and induction will identify adequate training. Training schedule will identify dates for refresher courses. This which is now in place. The centre manager will review personnel files to ensure all training is up to date. Training database will have section verifying that all certs have been received post training.
	The centre manager must ensure oversight of young people's plans to ensure the content and language is appropriate and that recommendations of specialists are evidenced and actioned.	Young person's file audit is underway as of 30/01/2020 to ensure content and language is appropriate this is overseen by the centre manager. Guidance has been given to staff team to reference any recommendations of specialist. Report writing training is scheduled for the organisation date has to be confirmed. Supervision to address any issues with staffs report writing skills and quality. The centre	All staff will attend report writing training. The centre manager will ensure all actions from audits are followed in full.

		manager has a workshop scheduled 18th Feb 2020 to address issues and explore outcomes of YP file Audit.	
	The centre manager must ensure that there are appropriate mechanisms in place to ensure that young people do not have to wait for availability of keyworkers information or completion of required tasks.	The centre manager has addressed this in supervision with staff team. This is also addressed in handover daily since the inspection and is written in the communications book. Keyworking as a shared responsibility will feature on the agenda for all team meetings going forward. The centre manager has scheduled a keyworking workshop 10th March 2020.	The centre manager will have oversight of this through audits, supervision and communication with young people and Social workers feedback.
	The director of service and centre manager must ensure that clarity is provided to all staff and all relevant people in respect of restrictive practices including physical intervention.	Restrictive *practice policy circulated* in draft form 24/01/2020 for comments and consultation. Policy will be presented to the policy working group on the 4th February 2020. All staff will read and sign this policy. This will be addressed in supervision with all staff. The centre manager will ensure all young people's files reflect any restrictive or physical interventions in place and keep a log of these.	The director of service and the centre manager will have oversight and adherence to the policy and procedures in place. Audits in place and completed by the director will identify any deficits.

	The director of service and centre manager must ensure that notification, auditing, tracking and conclusion of complaints is in line with national standards.	The centre manager will ensure that all relevant parties are notified in a timely manner when a complaint is made. The centre manager will implement the capture and tracking of low level complaints and ensure that actions are followed up. Through audits the centre manager will ensure that the complaints policy is adhered to through all steps taken to bring the complaint to a resolution. The centre manager will forward all complaints to the director of service who will track and return a director's complaint report which may include recommendations and actions. The centre manager will ensure these actions are followed.	The director of services and the centre manager will ensure required actions are followed in full. The social work department will be informed in a timely manner in respect of all complaints. The director of services will audit centre manager will audit the complaints system.
	The director of service must ensure that there is internal and external auditing of approaches to behaviour management.	As per standard 3.2.5 The director of services has *circulated* in draft form a positive behaviour *practice policy* 24/01/2020 for comments and consultation. Policy will be presented to the policy review working group on the 4th February 2020. All staff will read and sign this policy. This will be addressed in supervision with all staff. The centre manager	Internal and external audits carried out by the centre manager and director of services will highlight any deficits. The centre manager will ensure all actions are followed up. The centre manager will ensure a triangulation of all approaches to positive behaviour are carried out and documented accordingly.

		will ensure all young people's files; ICMPS, behaviour support plans and TCI interventions are reflected.	
	The director of service must ensure that there are mechanisms in place to receive formal feedback from parents and significant others and include this in service improvement plans.	The director of services and centre manager is developing a questionnaire for parents and social workers. This will be sent out bi-annually for feedback and comments. This will be complete end of February 2020. The centre manager will ensure feedback and comments will be considered in all service improvement plans.	The centre manager and director of services will audit and analyse feedback and ensure all actions are followed up. The centre manager will ensure that the social workers and family will receive feedback and assurance of actions completed.
5	The director of service must ensure that their audit framework is benchmarking policy and practice against regulations and the National Standards for Children's Residential Centres, 2018 (HIQA). Specific action plans with formal follow up must be created to address any deficits in compliance.	The director of services has developed an external audit tool measured against the regulations and National standards for Children's residential centres, 2018 (HIQA).	The director of services will ensure all actions are followed up and all deficits highlighted are addressed through supervision with centre manager. The centre manager will ensure all actions are followed up and completed.

	The director of service must ensure that all issues including those relating to supervision, staffing, records and governance as outlined in this report are addressed as a matter of priority.	The director of services has reviewed all actions in this report and will ensure this is completed. The centre manager has implemented a tracking document to ensure supervision as per the guidelines of the supervision policy. The centre manager will address staff issues in supervision. In addition to this, the centre manager will facilitate a teambuilding day which will take place 4th Feb 2020. The director of service has begun an external audit to address the actions required.	The director of services will review all issues requiring actions at management meetings to ensure compliance across the organisation.
	The director of service must ensure that there is clear direction on who acts up while the manager takes periods of leave.	The statement of purpose and function states as per job description that the deputy manager will act up while manager takes periods of leave. This has been circulated by director of services to deputy manager.	The director of service will ensure that the statement and purpose and function are circulated to all current and future deputy managers. The director of service will ensure clarity is given to deputy manager around role and responsibility.
	The director of service must ensure that there is clarity regarding the position and role of deputy social care manager and their responsibilities.	The director of service will ensure clarity is given to deputy manager around role and responsibility. The centre manager will ensure through supervision that clarity is provided going forward. A review of the deputy	The director of service will ensure clarity is given to deputy manager around role and responsibility.

		manager role will be conducted by the director of service.	
	The director of service e and social care manager must ensure that there is a log for delegation of duties by the manager to deputy and social care leaders	The centre manager has developed an electronic log for all delegated duties. This has been circulated to managers, deputy manager and the director of service for consultation. It was agreed that all centres will use this log to ensure compliance with the national standards. The centre manager will ensure this log is completed and actions on it are followed up.	The director of service and the centre manager will review this and maintain the log. The director of service will have oversight through the external audit measured against the HIQA themes and standards.
	The director of service must ensure that there is a review date for the purpose and function and policies and procedures.	The director of service has circulated policy for consultation and they will be reviewed beginning on the 4th February 2020. These policies will be sent to the Board for final agreement. The director of service will ensure that when they are agreed that the statement of purpose and function and all policies will have a review date.	The director of service will ensure during on-going review of policies that correct review dates are included.
	The director of service must ensure full implementation of	The director of service has developed an audit tool which has a built in review and audit for	The director of service will ensure and review all audit findings and through management

	inspection recommendations with on-going review through auditing processes.	full implementation of inspection recommendations. The centre manager will ensure all actions from the audit are followed up.	meetings, appropriate forums, working groups and supervision ensure recommendations are maintained.