An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 080

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Compass CFS Ltd**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced themed inspection**
Date of inspection:	**05th, 06th and 18th January 2022**
Registration Status:	**Registered from the 13th June 2021 to the 13th June 2024**
Inspection Team:	**Linda Mc Guinness** **Lorna Wogan**
Date Report Issued:	**14th April 2022**

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 August 2015. 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 the 13th of June 2021 to the 13th of June 2024.

The centre was registered as a multi-occupancy, to provide care for three young people of both genders from age thirteen to seventeen years on admission. Their model of care was described as a relational based model underpinned by the principles of social pedagogy. The basis for this programme was that professionally qualified adults care for the young people in a consistent and predictable fashion. A primary focus of the work with young people was informed and guided by an understanding of attachment patterns.

There were three young people living in the centre at the start of the inspection, with one moving on to a planned aftercare arrangement during the inspection process. The centre was granted a derogation for one of the children as they were under-thirteen years of age on admission, and this was outside the age range identified in the centre's statement of purpose.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 14th February 2022. 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 28th February 2022.

The findings of this report and assessment of the submitted CAPA deem the centre not to be operating in adherence with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III Article 5: *Care Practices and Operational Policies*. As such, it is the decision of Child and Family Agency register this centre, ID Number: 080 with attached conditions from the 13th of June 2021 to the 13th of June 2024 pursuant to Part VIII, 1991 Child Care Act.

The condition being:

- There must be no further admissions of a young person under 18 to this centre until there is a review of the implementation of the corrective and preventative action plan to comply with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 5: *Care Practices and Operational Policies*.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17 Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

Inspectors found that one young person had an up-to-date care plan dated October 2021 and a child in care review was scheduled for April 2022 which was within the regulatory timeframe. Inspectors found that this was a detailed and comprehensive assessment of needs with specific actions agreed by all relevant people. The team prepared a comprehensive report for the initial child in care review and minutes of this meeting were available on site. The young person was provided with an opportunity to participate in their care plan review meetings but declined and the team advocated on their behalf. The third young person turned 18 years of age during the inspection and made a planned move to an aftercare service. As such their file was archived and not reviewed as part of this inspection.

The second young person was under 13 years of age and subject to a derogation to the statement of purpose. In general, the statutory reviews were in line with the National Policy in relation to the Placement of children aged 12 years and under in the Care or Custody of the Health Service Executive, which requires monthly reviews. The most recent care plan on file was dated November 2021, which was outside the required timeframe, but this was explained to inspectors in the context of a change in social worker. The newly appointed social worker had planned to meet the young person and convene a review meeting at the time of inspection.

Inspectors found that while care in the centre was child focused and young people had made progress, there were deficits in how the goals of care plans were incorporated and tracked through the placement planning process. The system in place did not meet the requirements of national standards. Some aspects of one young person's care plan had no evidence of follow up in the placement plans on file.

Inspectors found that the centre did not adhere to its own policy in respect of placement planning. The placement plans were not always forward planning, and

they did not reflect key tasks decided at a child in care review. Inspectors found that tasks were not assigned to specific staff and that oversight of the process required immediate attention. Placement plans were not up to date and there was no evidence of review of outcomes on some previous plans. There was no evidence that, with the support of staff, young people contributed to setting personal and individual goals they wished to achieve, and improvements were required to record the involvement of families where appropriate. Furthermore, some plans contained outdated information and there was evidence of copy and paste of goals from month to month.

Some of the issues identified in respect of placement planning were also findings in previous inspections of this centre. An external audit of October 2021 by the head of service identified that planning for young people 'should be completed in a proactive, planned and co-ordinated manner and there needs to be clear evidence of manager oversight and governance in relation to this process'. Also, the previous deputy manager conducted quality checks on young people's files, and they identified similar deficits relating to placement plans. Inspectors did not find that there was a robust and timely response to these identified deficits.

There was some evidence of discussions relating to planning at team meetings however this lacked clear focus. These meetings did not take place fortnightly in line with organisational policy. Planning was also discussed in a forum known as clinical supervision which involved the organisations' psychologist. Some of these records were comprehensive and guided practice while others were brief updates of young people's current issues. There was no evidence of outcomes of suggested interventions or how clinical advice or guidance improved practice or outcomes. There was no record of who attended these meetings. The clinical notes were not specific to each young person and held on their care file. Inspectors did not find a strong connection between the model of care and planning for young people through the team meeting or clinical supervision.

Each young person had assigned key workers however inspectors found that key working was not taking place in line with organisational policy and best practice. From a review of the young people's files and inspection interviews, inspectors did not find that regular key working aligned to care plans and placement plans was taking place. Much of what was reviewed were natural conversations or reactive work responding to escalation or upset of young people and was not planned and targeted work. For example, there was no evidence of key working relating to children's rights, complaints, bullying, safety in the centre or community or empowering people in care (EPIC). Individual staff supervision contained

discussions relating to relationships with young people but not placement plan goals or planned key working.

Inspectors found that specialist supports were facilitated through the care planning process. One young person was attending services, and another confirmed that they had been offered supports but declined to attend.

The organisation employed a consultant psychologist who worked with the team to support them with interventions and approaches to care however as outlined above this was not adequately recorded on centre records and young people's files. Training was provided to the staff team to ensure they were familiar and confident with the model of care.

Inspectors spoke with social workers for all young people living in the centre at the time of this inspection. In general, they were satisfied that the young people had made progress and that they were well cared for. Following a review of the care files and interviews with the allocated social workers and two Guardians ad Litem, it was evident that improvements were required to evidence the consultation with social workers and other professionals involved in the care of young people.

Compliance with Regulations	
Regulations met	**Regulation 17**
Regulations not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Not all standards were assessed**
Practices did not meet the required standard	**Standard 2.2**

Action Required:

- The registered provider must ensure that placement plans are up to date, forward planning and incorporate all aspects of the care plan.
- The registered provider must ensure that the placement planning process is reviewed, and that centre policy and procedure is followed. Each placement plan must outline the needs and supports required and that actions, persons responsible and outcomes are reviewed.

- The registered provider must ensure that key working is planned and proactive and aligned to the goals of the placement plans.
- The registered provider must ensure that there is evidence that young people contribute to setting personal and individual goals within the placement planning process and that families are provided with opportunities to contribute, in line with centre policy and national standards.
- The registered provider must ensure that issues arising through audits and quality assurance checks are actioned promptly and appropriately.
- The registered provider must ensure that there are comprehensive records of the input of the psychologist to support planning and that these are held on young people's files.
- The registered provider must ensure that all consultation with social workers and other relevant professionals is recorded on young people's files.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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

Inspectors found that the organisation had governance arrangements and management structures defined in writing that set out lines of authority and accountability. Each staff member had a job description appropriate to their role. From review of records and staff interviews inspectors did not find evidence of a comprehensive induction process. From a review of centre documents and exit interview inspectors found that the deputy manager who recently left the service was not adequately inducted into or supported in the post. There was a requirement for more specific induction and training processes for roles such as the deputy manager and social care leaders.

Following a review of centre records, interviews with staff and external professionals the inspectors found there were deficits in respect of evidence of internal and external management and leadership in the centre. Examples of this are detailed further throughout this report.

The centre manager was the appointed person in charge and was appropriately qualified and experienced to undertake the role. They held the overall executive accountability for the delivery of this service, and they were also the centre manager and named person in charge for another centre. The manager reported to the regional residential service manager.

Inspectors found from observations and inspection interviews that there was an emphasis on child centred care. Both young people who met with inspectors stated they were happy in their placements and liked living there. Notwithstanding this, inspectors did not find strong systems of governance across the organisation and there was lack of evidence that internal and external management had effective oversight on all areas of practice. The findings throughout this report have identified deficits and areas that require attention.

It was difficult to find evidence of robust oversight of safe and effective care led by the centre manager and deputy manager. The centre manager and deputy manager were not based in the centre. The rationale for this was to create a more homely environment in line with the model of care in place and to facilitate the social pedagogues to build strong relationships with the children.

Staff and young people confirmed that the manager, deputy, regional manager and CEO had visited the centre and they were familiar with them. However, review of centre policies stated that managers would have a regular presence in the centre and inspectors could not find evidence that this was the case. The systems to record how managers fulfilled their responsibilities and evidenced their governance and oversight were inadequate. It appeared from a review of documents provided that the centre manager had only visited the centre on six occasions since the last inspection in April 2021 to the end of year. The records indicated that the deputy manager was present on nineteen occasions and the regional manager on four occasions in the same period.

There was also a lack of clarity in respect of roles and, as the centre manager was the person in charge for two centres many of the tasks of managing the centre fell to the deputy manager. Inspectors were informed that the deputy manager visited the centre for approximately an hour to attend handover meetings each day from Monday to Friday. While staff who were interviewed confirmed that they had a regular presence it was not recorded on handover or centre records and there was no evidence of guidance and direction provided to the team at this forum. Some of the deficits in planning described under Theme 2 were identified in an external audit but

were not promptly addressed through good governance practices. Since the deputy manager left the centre at the end of 2021 there was no evidence that a manager had attended the handover meeting in 2022. There was written evidence that the tasks of the deputy reverted to the social care manager following their resignation, but this did not happen in practice.

One social worker described that the centre had moved away from a full social pedagogy model more towards mainstream residential care however, the managers had continued to be office based off site. The social worker noted that this had some impact on planning as managers may not always be aware of specific details of events and would have to wait until the staff member involved returned onsite. Inspectors concur that the practice of having both managers off site has impacted on effective leadership, governance and management and that planning for young people was consequently affected.

Inspectors noted that, despite deficits in governance systems and evidence of oversight, staff interviewed during inspection expressed confidence in all levels of management stating they were 'accessible and supportive when needed'.

The inspectors reviewed documentation relating to an investigation that took place following an incident that occurred at the centre. Following an extensive review of documentation and interviews with professionals, inspectors found that this investigation was not a full and thorough process and analysis of safe practice. There were deficits in terms of process, recording, findings, communication with professionals and implementation of actions.

Inspectors found that there was some confusion about the status of the current suite of policies and procedures and whether the updated suite of policies were approved and signed off. There was no evidence that new policies were communicated to staff or training provided. The policy document also required dates of review and page numbers.

Inspectors reviewed a range of centre records including team and management meetings, significant events and staff supervision records. They found that improvements were required to ensure that a culture of learning was evident in practice.

Inspectors found that the auditing systems in the centre had improved since the last inspection but still required attention. Two audits had been completed on Theme 1

and Theme 6 of the National Standards for Children's Residential Centres, 2018 (HIQA) however there was no evidence that these audits were closed out or that issues identified were addressed. While it was positive that audits were planned and scheduled in advance, findings across this inspection should have triggered responsive audits based on incidents and patterns of concerns. Actions arising from inspections across the organisation were discussed at management meetings however, there was no system in place at the time of inspection to share learnings from audits across the organisation. At the time of inspection there was limited capacity to audit each centre annually against all of the eight themes of national standards. This compromised the ability to provide a comprehensive annual review of compliance.

Inspectors found that there were serious deficits in respect of review of significant events. Incidents were not reviewed in line with centre policy and some serious incidents did not result in convening a significant event review group (SERG). There was a lack of clarity about what would trigger a SERG, for example physical interventions did not result in formal review for learning purposes. There was an absence of information relating to analysis, review and outcomes of significant events. Recording of incidents required immediate action. The manager was unaware of one incident for a young person subject to derogation. Also patterns of behaviour which potentially could negatively impact this young person were not thoroughly analysed and the records on file provided limited information as to how this issue was being addressed with them. Evidence of learning from review of incidents was not evident across records reviewed during this inspection. In one instance a staff member who was on protected leave while an incident was being reviewed/investigated was returned to their position prior to consultation with the supervising social work department.

Inspectors found that attendance at team meetings was very poor for some staff and there was no evidence that this was highlighted through internal or external management and oversight of the centre.

The organisation was procured to provide a service to the Child and Family Agency through Tusla's national private placement team (NPPT). An annual compliance report and service improvement plan was submitted to the NPPT and there was regular communication between the parties.

There was a risk management policy and framework in place as required. Staff interviewed were familiar with current risks for each of the young people living there.

Inspectors found a lack of evidence of oversight of risk by internal and external management through their visits to the centre or in samples of management meetings reviewed during inspection. There was reference to the framework at management and team meetings although some improvements were required to ensure the effective identification, assessment and management of risk. Inspectors identified two issues that should have been on the risk register to facilitate effective tracking and management. Staff interviewed were not clear in respect of scoring of risk stating that this was done at management level. The risk framework itself was set out in policy however it was not applied effectively in practice. Further clarity was required in terms of systems to measure, score, mitigate, escalate and follow up identified risks.

Inspectors also found that the system in place for pre-admission risk assessment was generic and did not provide specific risks to consider possible impact on young people being referred or those already resident. A more robust process which included individual and collective risks, control measures and necessary actions was required.

Inspectors found that the risks associated with the Covid-19 pandemic were well managed across the organisation. There was prompt and regular access to personal protective equipment, cleaning materials and sanitiser. Policies and protocols were reviewed in line with guidance and advice from the National Public Health Emergency Team and government guidelines.

There was a delegation record that set out tasks assigned by the manager to other members of staff. It was not clear from this record what tasks were delegated to the deputy or others during periods of leave by the manager. There was no deputy in place at the time of inspection and while a meeting record stated that their tasks had been reassigned to the centre manager this had not happened in practice. Inspectors were informed that when the regional residential service managers took leave a named person was assigned as a contact person for the centre manager.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards were assessed**

Actions Required:

- The registered provider must ensure that there are specific induction/training processes and supports for roles such as the deputy manager and social care leaders.
- The registered provider must ensure that these are strong systems of governance across the organisation and robust evidence that internal and external management have effective oversight on all areas of practice. Deficits identified though audit processes must be addressed without delay.
- The registered provider must ensure that there are robust systems in place to record how all levels of management fulfil their responsibilities including the time they spend on site and work they complete.
- The registered provider must assess the capacity of the centre manager to be responsible and accountable for two services.
- The registered provider must ensure that any investigation required is a robust and thorough process with clear terms of refence, methodology and that findings are communicated to all relevant people. Any learning identified following an investigation must be implemented without delay.
- The registered provider must ensure that the suite of policies and procedures is completed, signed off, formally communicated to staff and training provided if required.
- The registered provider must ensure that there are systems in place to evidence that a culture of learning is evident in practice. Reviews of incidents must be completed in line with policy and learning shared with staff teams.
- The registered provider must ensure that any physical interventions are subject to formal review and that there is evidence of this on young people's care records.

- The registered provider must ensure that team meetings take place in line with policy and that non-attendance is managed through effective oversight and governance.
- The registered provider must ensure that there is a system for the effective identification, assessment and management of risk. All risks must be recorded, and staff must be fully aware how the risk is scored and managed in line with policy.
- The registered provider must ensure that each pre-admission risk assessment adequately considers possible impact on young people being referred or those already resident. They must be specific to the presenting behaviours of each young person and include individual and collective risks, control measures and necessary actions.
- The registered provider must ensure that all required actions are completed following inspection processes.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found that there were systems in place to manage the workforce in the centre. Recruitment, annual leave and staff retention was discussed at team meetings and residential management meetings.

The staff team had remained relatively stable since the last inspection. One staff member moved to another centre within the organisation and another two had left during 2021. These two people were replaced with people who had been providing relief cover, so they were familiar to the young people. At the time of this inspection the staffing complement consisted of the social care manager, deputy manager, three lead pedagogues, seven social pedagogues. Inspectors found that this was sufficient staff for the number and needs of young people at the time of inspection. One staff member was unqualified and had committed to attaining a social care or relevant qualification at the time of the last inspection of this service. This was on hold at the time of this this inspection and inspectors noted that this staff member had recently been appointed to the position of lead pedagogue. This was not in compliance with

the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).

Double cover was always provided. At the time of inspection two staff members worked a twenty-four-hour shift and slept overnight in the centre and a third person was to provide a day shift from 8am until 11pm.

The times that staff worked were not recorded on the rota and it was difficult to determine the actual start and finish times of these shifts. On the day of a serious incident the person assigned to the day shift did not commence work until 3pm. Staff starting shift late was not entered on to the centre risk register or considered in the investigation into the incident referenced earlier in this report.

During a period in summer 2021 a decision was made to reduce staffing to double cover as there were only two young people living in the centre. There was evidence that the staff raised concerns about staff being sent to work in another centre when they were needed in this centre due to the concerns about the behaviours of one young person. Inspectors did not find that this was adequately risk assessed and on one occasion resulted in one staff member having to conduct a physical intervention when they were alone in the house with this young person. A significant event review group was not convened to review this incident.

The post of deputy manager was vacant at the time of inspection and the organisation was actively recruiting for a new deputy manager.

While there was normally a dedicated panel of relief staff for the centre to cover annual leave and other types of leave, at the time of inspection only one person was available to cover shifts if required. There was an ongoing recruitment drive to ensure the centre had a panel of support staff as required.

Inspectors found that there was an emphasis on staff retention and maintaining a stable core team. Discussions were taking place at management level to consider additional employee benefits to promote staff retention. The organisation supported further training and there was an employee assistance programme to support staff if required.

Inspectors reviewed records of exit interviews which took place recently. While the quality of the records were of a good standard and provided valuable information it was not evident how exit interviews were used to inform service improvement.

The centre manager organised the roster to ensure there was a lead pedagogue working each day. The inspectors found that more management presence and oversight was required to assess fully if staff had the necessary skills, competencies and experience to meet the needs of the young people. Review of incidents, centre records and supervision files indicated that some staff required additional support and direction. Staff appraisals were not taking place in line with policy, and this was a required action from the last inspection of this service.

There was a formal on call policy and procedure in place as required. Staff reported that this was effective in practice.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards were assessed**

Actions Required:

- The registered provider must ensure that there is an adequate panel of relief/support staff to provide cover for annual and other types of leave.
- The registered provider must ensure that decisions to reduce staffing are adequately risk assessed and reconsidered if a risk increases.
- The registered provider must ensure that the hours staff work in the centre are accurately recorded on the centre rota.
- The registered provider must ensure they are operating in compliance with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020). All staff must hold a social care or relevant qualification. Unqualified staff must not be promoted to roles of leadership and responsibility.
- The registered provider must ensure that there is a record of analysis of trends and patterns from exit interviews and evidence how these are used to inform service improvements/retention of staff.

- The registered provider must ensure that the role of centre manager is reviewed to ensure there is a physical presence onsite to ensure robust oversight of practice.
- The registered provider must ensure that appraisals take place in line with policy

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered provider must ensure that placement plans are up to date, forward planning and incorporate all aspects of the care plan.	All placement plans for the young people in the centre are up to date and in line with most recent care plans. The placement plan document has been updated to support forward planning. The head of services provided training for the team on the updated placement plan document and is monitoring it's implementation.	Each young person's placement plan is updated on a monthly basis and reviewed and signed by the centre manager before being shared with the wider professional team. During the implementation phase all placement plans will be reviewed by the regional manager and the placement planning process will be monitored on an ongoing basis through external audits. The social work department and other relevant professionals will be provided with a monthly progress report on each young person.
	The registered provider must ensure that the placement planning process is reviewed, and that centre policy and procedure is followed. Each placement plan must outline the needs and supports required and that actions,	An enhanced placement planning process has been implemented that is in line with policy and that will ensure that the placement plan is informed by the care plan, be comprehensive in terms of the needs of the young person and will be	Training on the new placement planning process will be provided to all managers at the residential managers meeting scheduled for March 23rd. Care planning will be monitored by the regional manager and head of services

	persons responsible and outcomes are reviewed.	shared and agreed with the social work department monthly. There will be clearly identified areas of responsibility in relation to actions within the placement plan and these will be reviewed monthly.	monthly to ensure the new placement planning process is embedded in practice. The head of services will report to the CEO as part of the monthly governance meeting on placement planning and its effectiveness.
	The registered provider must ensure that key working is planned and proactive and aligned to the goals of the placement plans.	There are now specific intervention goals and key working pieces identified in the placement plan with oversight from the centre manager. A schedule of key working sessions for the month is drafted following the completion of the monthly placement plan with individuals identified for having responsibility for completion of these. A register of key working/individual work has been developed for each young person to ensure planned and pro-active key working is completed.	Key-working is a standing item on team meetings and engagement and progress in relation to goals will be reviewed and discussed on an ongoing basis. The centre manager will ensure focused key working takes place and this is evidenced in their monthly quality assurance audit. The regional manager will review key working practices through the external audit process.
	The registered provider must ensure that there is evidence that young people contribute to setting personal and	Key working sessions have been completed with the young people in relation to their placement plans for the month and they	Placement plans and goals will be reviewed with the young people monthly. The young people will be supported and encouraged

	individual goals within the placement planning process and that families are provided with opportunities to contribute, in line with centre policy and national standards.	have participated in the development of their goals and this is recorded as individual work. Families are invited to child in care review meetings as guided by the placing social worker. Their input and feedback is welcomed via this platform.	to actively participate in age-appropriate goal setting and plans to achieve these goals. This will be documented as individual work and the centre manager will review these records. These records are also subject to regular external auditing by the regional manager. The young people's parents/guardians will be provided with a monthly progress report as appropriate and as guided by the placing social work department.
	The registered provider must ensure that issues arising through audits and quality assurance checks are actioned promptly and appropriately.	All issues identified though audits and quality assurance checks have been actioned. The internal and external auditing procedure has been reviewed. Once the audit has been completed the findings of the audit are shared with the manager within 2 weeks, inclusive of an action plan. The action plan is in line with Tusla's CAPA structure to ensure preventative actions are implemented. Any findings requiring urgent attention will be addressed immediately.	The regional manager will visit the house at least once per month and the internal audits will be reviewed monthly to ensure that these are being completed and that there is appropriate follow through on all identified actions. All completed external audits will be shared with the head of services for review. An annual schedule of audits is in place. Responsive audits will be completed as required by the head of services.

	The registered provider must ensure that there are comprehensive records of the input of the psychologist to support planning and that these are held on young people's files.	Clinical team meetings now have a set agenda and the emphasis will be on reviewing and developing the young person's clinical and therapeutic goals. The clinical psychologist has developed an individual therapeutic plan for each young person. These are now reviewed monthly with the team in clinical meetings. The individual therapeutic plan is filed in the young person's care files.	Following each review, the young person's individual therapeutic plan will be updated and there will be a record of this in the young person's files. The individual therapeutic plan is shared monthly with all relevant professionals. Centre managers are required to attend clinical meetings. The regional manager is required to attend clinical meetings periodically throughout the year.
	The registered provider must ensure that all consultation with social workers and other relevant professionals is recorded on young people's files.	Monthly individual placement plans, individual support plans and monthly progress reports are now shared with the social worker and relevant professionals. All other additional contact is recorded and reviewed by the manager on an ongoing basis and records of this contact with the centre is stored on young people's files.	The young people's files are audited by the case manager on a monthly basis to ensure that all relevant documents are in place and filed correctly. In addition to this the regional manager will review the files monthly to ensure that this process is being carried out to the required standard.
5	The registered provider must ensure that there are specific induction/training processes and supports for roles such as the deputy	The induction process for all roles is currently under review to ensure all responsibilities are understood by the employee, with greater management	The regional manager will carry out a review of the induction and probation period and ensure a process is followed where induction and probation are kept

	manager and social care leaders. The registered provider must ensure that there are strong systems of governance across the organisation and robust evidence that internal and external management have effective oversight on all areas of practice. Deficits identified though audit processes must be addressed without delay.	oversight. An induction programme for management and leadership positions will be developed and overseen by the regional manager. Governance and auditing systems are under review by the senior management team to ensure effective oversight on all areas of practice. Records in the centre are subject to daily review by the residential services manager, who is based on-site for significant portions of the week, and for longer periods when the needs of the young people require this. The auditing schedule for 2022 will focus on ensuring care practices are of good quality and that management oversight is effective. The external auditing policy has been updated and it clearly outlines the procedure to ensure that all identified issues are addressed in a timely manner.	under review and training needs/areas of development are identified. Induction policy to be updated to reflect clearer processes for management and social care leader positions. Q2, 2022. The regional manager will visit the centre at least monthly and carry out external auditing as part of these visits. Where areas of immediate concern are identified they will be addressed immediately. The policy on external auditing has been updated to include the requirement for the audit report to be given to the centre manager within two weeks, and an action plan, with suitable timeframes developed. Actions plans are reviewed by centre managers at the weekly planning meeting. The head of services will carry out the responsive auditing function, based on concerns or practice issues identified outside of the auditing process.

	The registered provider must ensure that there are robust systems in place to record how all levels of management fulfil their responsibilities including the time they spend on site and work they complete.	Members of the management team record all visits to the centre in the visitors' log along with the purpose of the visit. A manager is now on site daily. All care records are reviewed prior to hand over. Managers signs the daily shift planner to verify that they have reviewed the morning handover, and any direction given.	The regional manager will review this practice monthly as part of their oversight of the centre. The CEO meets with the head of services and regional manager on a monthly basis in the form of a governance meeting. The first meeting took place in February and outlined clear governance responsibilities for each role inclusive of expectation regarding time on site.
	The registered provider must assess the capacity of the centre manager to be responsible and accountable for two services.	Following review of the governance structure for this centre and feedback from the centre manager, the centre manager is now solely responsible for the management of this centre. Effective. 31.01.2022.	The CEO, head of services and regional manager will continue to monitor the governance of all centres at the monthly governance meeting.
	The registered provider must ensure that any investigation required is a robust and thorough process with clear terms of refence, methodology and that findings are communicated to all relevant people. Any learning identified	The regional manager will provide clear terms of reference and methodology for any future investigation processes. Learning from investigations will be shared at management meetings, where appropriate, to ensure learning takes place	The head of services will have oversight of investigation reports and ensure correct processes are followed. The CEO will ensure a policy is approved and implemented to support the internal investigation process. Q.2. 2022

	following an investigation must be implemented without delay.	across the organisation. A policy will be drafted in which gives a process for any investigation, which includes terms of reference, methodology and reporting requirements.	
	The registered provider must ensure that the suite of policies and procedures is completed, signed off, formally communicated to staff and training provided if required.	The suite of policies and procedures is currently being updated to final completion and will be shared with the staff team upon completion. June 2022. A training schedule for 2022 on policies and procedures has been agreed and will be implemented.	The regional manager has oversight of the policy and procedures process and responsibility for training being provided in this area. The organisation has employed a policy developer and researcher with extensive background in this area to oversee the development and implementation of the suite of policies.
	The registered provider must ensure that there are systems in place to evidence that a culture of learning is evident in practice. Reviews of incidents must be completed in line with policy and learning shared with staff teams.	A policy on significant event review has been finalised and a new SERG process implemented within the organisation. Included in this policy is the requirement to share the findings of SERG and other review processes with the staff team. This will be carried out by the centre manager.	External auditing of the centre will include oversight of incident review and shared learning.

	The registered provider must ensure that any physical interventions are subject to formal review and that there is evidence of this on young people's care records.	All physical interventions are now subject to SERG review and a record of the findings will be held on the young person's care file.	External auditing of the centre will oversee that records of reviews are kept on the child's care record.
	The registered provider must ensure that team meetings take place in line with policy and that non-attendance is Managed through effective oversight and governance.	Team meetings are held fortnightly and chaired by the centre manager. Expectations around attendance at team meetings has been communicated to the team and the centre manager will monitor attendance and ensure accountability in this area.	Team meeting minutes are subject to monthly review by the regional manager to ensure minutes are of good quality and attendance is monitored. A policy will be drafted in Q2 2022 to guide the management of attendance.
	The registered provider must ensure that there is a system for the effective identification, assessment and management of risk. All risks must be recorded, and staff must be fully aware how the risk is scored and managed in line with policy.	The centre risk register is reviewed monthly by the centre manager. The risk register, scoring criteria, and risk management policy will be communicated to the staff at a team meeting and kept under review by the team. An individual risk register has been introduced for each young person and the risk assessments now include a risk rating matrix.	The risk register will be updated monthly in line with policy and risks will be escalated appropriately. The regional manager will audit the risk register throughout the year to ensure all risks are recorded, identified, scored, and managed appropriately. The manager will review and sign off on all completed risk assessments.

	The registered provider must ensure that each pre-admission risk assessment adequately considers possible impact on young people being referred or those already resident. They must be specific to the presenting behaviours of each young person and include individual and collective risks, control measures and necessary actions.	The pre-admission risk assessment process currently includes an admission risk assessment and impact risk assessment which takes into consideration all other residents of the house. The head of services will review all existing risk assessments and where required update impact risk assessments to address any deficits. A new admission process is already active with the head of services and senior clinical psychologist central in the referral and pre-admission process. The process identifies all risks associated with a potential new admission and include any potential impact on young people currently in residence. Where risks are identified, they will be managed under the revised risk management framework.	The updated pre-admission risk assessment process will be reviewed annually as part of the annual policy review process.
	The registered provider must ensure that all required actions are completed following inspection processes.	The CAPA from inspection processes will be reviewed by centre management at the weekly planning meeting and responsibility assigned for the completion of actions.	The head of services and regional manager will review action plans monthly as part of their governance of the centre. The head of services will ensure that all required actions are completed following

			inspection processes. This is monitored through the service development plan. Any actions that cannot be completed for whatever reason will be escalated to the CEO and ACIMS.
6	The registered provider must ensure that there is an adequate panel of relief/support staff to provide cover for annual and other types of leave.	There is an ongoing recruitment process for additional support staff to ensure adequate staffing numbers are maintained. The manager will provide the regional manager with a monthly assessment of staffing levels to ensure effective workforce planning.	There are a range of staff supports in place to promote staff retention and continuity of care to ensure children experience stability. Workforce planning will be monitored by the CEO in the monthly governance meeting.
	The registered provider must ensure that decisions to reduce staffing are adequately risk assessed and reconsidered if a risk increases.	Any future decisions to reduce staffing will be based on a risk assessment completed by the centre manager and subject to frequent review to ensure staffing levels are adequate and responsive to the needs of the young people.	These risk assessments will be subject to review by the regional manager who will be informed immediately of any decision to reduce staffing levels in the centre. The risk escalation process will be followed if required.
	The registered provider must ensure that the hours staff work in the centre are accurately recorded on the centre rota.	The centre rota has been updated to include start and finish times of scheduled hours and meetings.	The centre will keep records of planned and hours worked rotas which are subject to internal and external audit.

	The registered provider must ensure they are operating in compliance with the alternative care inspection and monitoring memo on staffing numbers and qualifications (February 2020). All staff must hold a social care or relevant qualification. Unqualified staff must not be promoted to roles of leadership and responsibility.	A training agreement is in the process of development with the identified staff member to ensure compliance with the memo on staffing numbers and qualifications (February 2020).	Since February 2020 all recruitment has been in line with the memo and all further recruitment and promotion within the organisation will be in line with the memo on staffing numbers and qualifications (February 2020).
	The registered provider must ensure that there is a record of analysis of trends and patterns from exit interviews and evidence how these are used to inform service improvements/retention of staff.	Exit interviews will be reviewed and analysed bi-annually at senior management meetings for the purposes of identifying trends and patterns and to inform service improvement.	The head of services has been assigned the responsibility of ensuring that this is taking place.
	The registered provider must ensure that the role of centre manager is reviewed to ensure there is a physical presence onsite to ensure robust oversight of practice.	The centre managers role has been reviewed. The centre manager is based on-site for significant portions of the week and reviews all records in the centre daily. Presence on-site is provided in both a planned and unannounced manner and the centre manager observes and reviews	The regional manager will keep this under review by visiting the house at a minimum of once per month and also through regular supervision of the centre manager.

		practice while in the centre. Furthermore, manager's presence on-site is guided by the needs of the service and young people and is responsive in its nature.	
	The registered provider must ensure that appraisals take place in line with policy	Appraisals for all staff will take place during 2022. A schedule of these have been drafted and these are commencing at the beginning of March 2022.	The regional manager will complete a bi-annual audit of personnel files and supervision records to ensure that this is taking place in line with policy.