An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 002

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Solis MMC Children's Services**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**03rd and 05th February 2020**
Registration Status:	**Without attached conditions from 05th of December 2017 to the 05th December 2020**
Inspection Team:	**Cora Kelly** **Sinead Diggin**
Date Report Issued:	**19th May 2020**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 05th December 2014. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from 05th December 2017 to the 05th December 2020.

The centre was registered to provide emergency respite accommodation to three young people (boys and girls) aged between 12 to 17 years. The centre operated three categories of placements. Firstly, those whose care placement had broken down and required a seven-day emergency bridging placement. Secondly, a 21-day placement to young people in an emergency situation who can return home or to their previous placement. Thirdly, emergency placements of twenty-four-hour duration. There were two children living in the centre at the time of the inspection. The relationship approach model of care was based on Erik K. Laursen's Seven Habits of Reclaiming Relationships. The model is based on the understanding that caring relationships are key to the development of resilience.

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 and to the relevant social work departments on the 12th March 2020. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 17th April 2020. 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: 002 without attached conditions from the 5th December 2017 to 5th December 2020 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The centre's child protection policies and procedures were last updated in January 2020. The inspectors found from the review of the document, with the exception of one area, that they were compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children Act, 2015. A deficit was found with regard to one aspect of the policy namely around reporting procedures and their understanding of mandated persons. It was stated in their reporting procedures that all child protection and welfare reports are to be sent to Tusla via the online portal system with the consent of the designated liaison person/centre manager or the on-call manager. The inspectors found from the review of information provided and gathered during the inspection that this was standard practice in the centre. This practice is not in line with Children First legislation. It was outlined in policy that all staff in the centre are mandated persons. The inspectors found from the list of mandated persons provided that not all staff met the mandated person's requirements. These findings were identified during the inspection of another centre within the organisation in 2019. The centre manager submitted an updated list of those deemed as holding mandated responsibilities following the onsite inspection. The child safeguarding statement (CSS) was up-to-date, publicly displayed and approved by the Tusla Child Safeguarding Statement Compliance Unit.

Procedures contained within the child protection policy document included those relating to bullying and peer abuse, lone working, safeguarding the rights of young people and anti-discrimination. The policy on online safety included procedures for dealing with possible exploitation on the internet and social media. Definitions, signs and features of child abuse were also included.

The centre manager was the appointed designated liaison person (DLP) with the deputy manager holding the deputy role. Both had participated in DLP training. Staff had received refresher child protection training based on the centres policies and procedures document in January 2020 and had completed the Tusla E-Learning module: Introduction to Children First, 2017. The inspectors viewed copies of the

certificates attained for both of these training programmes. In light of the inspector's findings with respect to reporting procedures and their understanding of mandated persons, the registered provider must ensure that the organisation's child protection policies and procedures are fully compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017 and that staff receive refresher training on the updated procedures to include reporting procedures for mandated persons and non-mandated persons.

From the inspector's review of questionnaires and in interviews staff demonstrated a good awareness of safeguarding policies and procedures guiding their work. In interview staff named safeguarding practices utilised in their everyday care of and interactions with young people. Their knowledge of reporting procedures reflected that highlighted in the policy document. From a management and quality assurance perspective, there was good emphasis on safeguarding policies, procedures and practices being addressed in centre audits and discussed in supervision and at team meetings.

The centre had a child protection register. The inspectors found from the review of the register that a small number of child protection reports that were correctly notified to Tusla through the online portal system were not closed. There was evidence of follow up by the centre in seeking outcomes for these. It was evident from the register that parents were informed of allegations and by whom. In the instances of keeping parents informed of incidents or allegations, the centre was directed by social workers in these instances.

It was evident from the review of young people's files and centre records that staff worked in partnership with young people's social workers to promote the safety and wellbeing of the young people. This was further verified though interviews with the young people's allocated social workers. Social workers completed the centres pre-admission risk assessments, attended admission meetings, received placement plans, activity risk assessments, weekly updates and notification of significant events. Given the emergency to short term nature of the placements that the centre operated from and direction from social workers, the opportunities for staff working in partnership with the parents and families was not always possible. When possible, records of young people's files and family contact evidenced this.

There was evidence that young people were assisted and supported to develop self-awareness and skills for self-care and protection and that this was based on their age, ability and circumstances. This was completed by staff during daily activities and individual work with the young people. Staff were found to have been promptly

responsive to the immediate needs of the young people and completed self-care and protection follow up work. Social workers corroborated this in interview. Strategies were in place to assist young people to disclose to staff when feeling unsafe or vulnerable. The centres system for addressing areas of vulnerability included pre-admission risk assessments, activity risk assessments, individual risk assessments, placement support plans and when required safety plans. The inspectors reviewed these documents across the review of young people's files and found that they were comprehensive and well connected. Safeguarding strategies were developed and monitored in response to the identified areas of vulnerability.

There was a policy and procedure on whistleblowing. In interview, staff were aware of whom they could make a protected disclosure to without fear of adverse consequences to themselves. The organisations consultant psychologist was named as a person with whom staff could raise their concerns.

Standard 3.2

The centre had a policy on the management of challenging behaviour, restrictive practice and their applied model of behaviour management. These in addition to the relationship approach model of care and individualised activity programme guided and supported staff in promoting a positive approach in managing challenging behaviour.

Training in a recognised model of behaviour management was provided internally within the organisation. It was outlined in policy that core training was to be undertaken by staff at induction stage or at the earliest stage upon employment in the centre to be followed by mandatory refresher training every six months. Significant deficits were found regarding the implementation of this policy. This was also identified by inspectors during the centres last inspection in August 2018 and was found to not have been identified by the quality assurance team during their 2019 audits. The inspectors addressed this issue with senior management following the inspection who accepted the findings. The service manager must ensure that all current training deficits are met immediately and that staff members are provided with TCI training in line with policy.

The inspectors did not observe behaviour management training certificates. This was addressed with the centre manager who advised that they are held in the organisations head office. In order to satisfy good practice around training the inspectors recommend that the centre manager regularly audits behaviour management training certificates.

Staff's everyday application of behaviour management techniques and their approach to promoting positive behaviour was evident during the inspector's review of paperwork relating to a sample of young people. These were evident in records relating to significant events and placement support plans that incorporated behaviour management, absence management, routine management and individual crisis management plans and individual work completed with young people. Due to the individualised programmes and staff supervision levels bullying had not presented as an issue in the centre to date.

The expectations of young people's behaviour were discussed at admissions meetings. Pre-admission risk assessments enabled staff to be informed of expected behaviours and allowed them to devise strategies to manage identified behaviours. Centre routines created boundaries, structure and consistency for the young people and for staff in managing behaviours. Through individual work there was evidence of staff supporting young people in understanding challenging behaviours.

Internally, there was evidence of young people's placement support plans being discussed, reviewed and monitored at team meetings in addition to young people's challenging behaviours.

In 2019 two of the five audits conducted by the organisations quality assurance department examined aspects of the centre's approach to managing behaviour that challenged. The inspectors found from the review of the quality audit reports that the use of physical interventions was not sufficiently examined namely the instances of physical interventions in January 2019 and June 2019. Gaps in the pre-admission risk assessment process and implementation of placement support plans were identified during the audits. It was found that clarification from a young person's social worker was outstanding with regard to the use of physical interventions and that placement support plans were not being updated monthly or when a new behaviour arose. Of the deficits identified it was evident that the centre manager actioned the findings within a set timeframe. It was observed from the review of the team meetings that feedback from these audits were discussed at team meetings. To improve the quality and safety of care provided by the centre the registered provider must ensure that the audits relating to the centres approach to managing behaviour that challenges comprehensively addresses significant incidents that have occurred in the centre.

A number of entries were recorded in the physical intervention register with the last occurring in September 2019. Physical intervention reports were completed by staff and reviewed by the centre manager with records held on young people's files. There

was evidence of relevant professionals including the parents of young people being promptly notified. Post physical intervention debriefing that was provided to staff by the centre manager, who was trained in post crisis debriefing training, did occur; however, time lapses were noted by the inspectors. Physical interventions were discussed during supervision and at team meetings. However, from the review of the team meeting minutes the inspectors were unable to determine if improvements in practice were identified during discussions at these meetings. The inspectors were advised that the physical interventions of January 2019 were discussed at a regional managers meeting in April 2019 and also a written report had been completed by the service manager. As the inspectors were not provided with requested paperwork relating to these they were not in a position to comment on the external oversight of the physical interventions episodes and of their views regarding the centres management of challenging behaviours.

A policy and procedure on restrictive practices had recently been implemented in the centre. Three restrictive practices were ongoing at the time of the inspection. Each had been assessed as being required for safety reasons and were subject to weekly review by the centre manager and at team meetings.

Standard 3.3

The inspectors observed an open culture within the centre whereby children were informed of the ways to raise concerns, reports incident and identify areas for improvements. Young people were advised of the complaints procedures and of the external support service available to them during the admissions process. They were also provided with information on 'know your rights' and on the centre's child safeguarding statement. Young person's participation was an agenda item at team meetings and mid placement feedback forms had been developed. It was found from the inspector's review of these forms that staff were supportive and helpful.

The inspectors reviewed the complaints register and found there were no formal complaints in 2019 to the time of the inspection informal complaints had been managed appropriately.

There were no formal mechanisms for parents or social workers to provide feedback. The registered provider must ensure that there are formal mechanisms in place so that significant people in young people's lives can provide feedback and identify areas for improvement.

The centre had a policy and procedure for the notification, management and review of significant events (SEN's). The inspectors viewed copies of SEN's held on young people's files that were entered into the centres SEN register. The inspectors found that they were reported to the relevant professionals. When possible, parents were informed in agreement with the young people's social workers. The centre verbally reported SEN's to social workers prior to issuing formal notification. In interview two social workers reported that the content and quality of the SEN's was good and one confirmed they received them promptly. The other social worker advised that although they received verbal notification the process for receiving formal notification was protracted as the centre didn't issue formal notification until the incidents had ended. This was proving difficult for the social worker who was collaborating closely with the young person's onward placement. They felt that it could lead to possible deficits in accurate information being passed on. The inspectors recognise that the events in question were over consecutive days. However, given the emergency and short term nature of placements the centre manager must ensure that SEN's are promptly reported in line with policy.

There was evidence of oversight of significant events by the centre manager. They were discussed and reviewed at team meetings and compiled into the young people's weekly reports. The inspectors found that there were deficits in the recording of the discussions on SEN's at the team meetings and namely what learning was achieved to inform future practices. The centre manager must review the mechanisms for reviewing SEN's so that learning reflects improvements in practice. It was indicated in policy that SEN reviews occur within each region each quarter where incidents relating to challenging behaviour and physical interventions would be reviewed. In 2019 one review meeting had been held the minutes of which were not made available to the inspector's despite being requested. The registered provider must ensure that SEN review meetings occur in line with centre policy and that learning is communicated to staff in the centre.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The registered provider must ensure that the organisations child protection policies and procedures are fully compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017 and that staff receive refresher training on the updated procedures to include reporting procedures for mandated persons and non-mandated persons.
- The service manager must ensure that all current training deficits are met immediately and that staff members are provided with TCI training in line with policy.
- To improve the quality and safety of care provided by the centre the registered provider must ensure that the audits relating to the centres approach to managing behaviour that challenges comprehensively addresses significant incidents that have occurred in the centre.
- The registered provider must ensure that there are formal mechanisms in place so that significant people in young people's lives can provide feedback and identify areas for improvement.
- The centre manager must ensure that SEN's are promptly reported in line with policy.
- The centre manager must review the mechanisms for reviewing SEN's so that learning reflects improvements in practice.
- The registered provider must ensure that SEN review meetings occur in line with centre policy and that learning is communicated to staff in the centre.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The organisation's quality assurance department held responsibility for ensuring that the centre's policies and procedures reflected up-to-date regulations and legislation. The centre's policies and procedures were last updated in January 2020 and from the review of same the inspectors found they were largely in compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). The updating process resulted in some changes to operational procedures within the centre. These were found to have taken place in a consultative manner from senior management level to staff working in the centre. The inspectors observed this from the review of senior management, internal management and team meeting minutes.

The quality assurance department held responsibility for conducting audits based on the National Standards for Children's Residential Centres, 2018 (HIQA). The procedure for conducting audits was comprehensive and addressed areas in detail. However, improvements are required in areas of non-compliance as identified in this report. Another area identified as requiring improvement related to the centres statement of purpose.

Through questionnaires and interview staff demonstrated a good understanding of legislation, regulations and standards guiding their work. This was evident too from the inspector's review of supervision records and team meeting minutes.

As previously mentioned the inspectors found from the review of the centre's child protection policies and procedures there was a deficit with the reporting procedures contained and their understanding of mandated persons. The registered provider must ensure that the centre is operating in full compliance with the requirements set out in the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First: National Guidance for the Protection and Welfare of Children, 2017.

Standard 5.2

There was a clearly defined external and internal governance structure in place in the centre with each individual having clearly defined roles and responsibilities that stipulated accountability. External governance comprised of the director, senior management team, quality assurance team, a consultant psychologist and human resource management. The centre manager, deputy centre manager, shift team manager and all staff were part of the internal governance system. The centre manager reported directly to a service manager, a member of the senior management team who also provided supervision to them. Reporting arrangements included the service manager being provided with daily reports that focused on the operational running of the centre and updates on the young people.

As outlined in policy the centre manager was charged with overall executive accountability, responsibility and authority for the delivery of the service. The inspectors found that the centre manager performed well in this area. They attended monthly senior management meetings, fortnightly shift team manager meetings and team meetings. Their leadership was demonstrated across various forums such as oversight of records relating to operational matters and the young people, compiling monthly governance reports, providing robust supervision, monitoring staff practice, responding to quality audits and providing feedback from audits at team meetings. The centre manager was supported by a deputy manager and a shift team manager.

This was found to have been appropriate to the size and purpose and function of the residential centre. The deputy manager had specific management functions that were discussed and reviewed in supervision and during internal management meetings. The inspectors review of relevant records and minutes reflected this including duties delegated and key decisions made. In interview the deputy manager was clear of their roles and responsibilities, acted-up for the manager in their absence and shared the on-call arrangement with the centre manager.

There was a service level agreement between the organisation and Tusla.

The centres risk management framework was outlined in policy. Included in this was the procedures for the identification, assessment and management of risk. The centre had a risk register that fed into an organisational risk register. A risk rating system was applied to manage identified risks that were subject to regular review and were accounted for in the monthly governance report completed by the centre manager. A sample of risk assessment tools used in the centre included pre-admission, activity, site specific and placement support plans.

Standard 5.3

The centres statement of purpose was last reviewed in January 2020. It was subject to annual review internally and externally with Tusla's National Private Placement Team from whom referrals to the centre are received. The aims, objectives and ethos of the centre was outlined in the statement. The day-to-day operation of the centre was not accurately reflected. The model of care was described in the statement and staff demonstrated in interview their awareness of the model and its implementation in practice. The statement was available to view in the staff office. The service manager must update the statement of purpose to ensure it accurately describes the day-to-day operations of the centre and that is fully compliant with the criteria outlined in the National Standards for Children's Residential Centres, 2018 (HIQA).

Standard 5.4

The organisation's quality assurance department, service manager and centre manager were the main guarantors for ensuring that quality and safe care was provided to young people. Internal governance processes were found to have been implemented in line with policy. With respect to external governance processes the inspectors identified areas of practice, as highlighted in this report that require significant improvement in order for the centre to be operating in compliance with the National Standards for Children's Residential Centres, 2018 (HIQA).

The inspector found that information relating to complaints and concerns and incidents was recorded, acted on, and monitored but there was a deficit in practice relating to this process being reciprocated for incidents. A shortfall of centre practice was that there was no evidence of learning from these incidents to have taken place externally. This has prevented any trends being identified and communicated to staff in the centre to promote improvements. The registered provider must ensure that external governance processes are comprehensively assessing and responding to deficits in practice so that good quality care and support is provided to young people.

An annual review of compliance with the centre's objectives had not been completed at the time of the inspection. The inspectors recommend that senior management develops a tool to annually review compliance with the centres objectives and that timely action is taken to promote improvements in work practices to achieve better outcomes for children.

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

Actions required

- The registered provider must ensure that the centre is operating in full compliance with the requirements set out in the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The service manager must update the statement of purpose to ensure it accurately describes the day-to-day operations of the centre and that is fully compliant with the criteria outlined in the National Standards for Children's Residential Centres, 2018 (HIQA).

- The registered provider must ensure that external governance processes are comprehensively assessing and responding to deficits in practice so that good quality care and support is provided to young people.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure that the organisations child protection policies and procedures are fully compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017 and that staff receive refresher training on the updated procedures to include reporting procedures for mandated persons and non-mandated persons.	The child protection policy has been updated by the quality auditor (Feb 2020). The policy has been submitted to the inspection and monitoring service. Staff have been informally updated on an individual basis to date. A formal update is scheduled for team meeting of 18th May 2020. Updated policies will be discussed at team meetings going forward.	The quality auditor will ensure child protection policies are in line with legislation and circulated throughout the organisation. The centre manager will ensure that the staff adhere to the policy.
	The service manager must ensure that all current training deficits are met immediately and that staff members are provided with TCI training in line with policy.	The service manager will ensure that all current training deficits are met by the 06.05.2020.	The service manager will aspire to carry out TCI refreshers every 3 months.
	To improve the quality and safety of care provided by the centre the registered provider must ensure that	Through interviews with staff and quality assessing centre records the quality auditor will ensure that future audits will	The quality auditor will ensure that regular auditing of the centres approach for managing behaviour that challenges takes

	the audits relating to the centres approach to managing behaviour that challenges comprehensively addresses significant incidents that have occurred in the centre.	address all significant incidents that occur in the centre. The quality auditor aims to have a full audit carried out by May 12th 2020.	place.
	The registered provider must ensure that there are formal mechanisms in place so that significant people in young people's lives can provide feedback and identify areas for improvement.	Feedback forms for social workers and/or parents were introduced by the centre manager in March 2020.	Centre manager will ensure the continued use of this feedback tool. Information received will be used for service development, decision making, etc.
	The centre manager must ensure that SEN's are promptly reported in line with policy.	The centre manager has introduced a change in how lengthy/prolonged SENs are circulated. These will now be circulated following each 24hour period. This will ensure it is in line with policy. The final SEN will be circulated when the incident is over.	The centre manager will ensure that SEN's are reported in line with policy timeframes. The quality auditor will also monitor this during audits.
	The centre manager must review the mechanisms for reviewing SEN's so that learning reflects improvements in practice.	The team meeting agenda has since been amended by the centre manager and *SENs & associated learning* is now a broader agenda item.	Centre manager and/or deputy manager will assure that this remains an agenda item indefinitely.

	The registered provider must ensure that SEN review meetings occur in line with centre policy and that learning is communicated to staff in the centre.	The service manager will ensure that these occur quarterly. The centre manager will inform the staff team of any relevant discussions/learning at team meetings. Upcoming meetings are scheduled as follows; 2nd April (completed) 2nd July 2020, 2nd October 2020, 2nd December 2020.	The service manager will ensure that SEN review meetings are held in line with the schedule devised.
5	The registered provider must ensure that the centre is operating in full compliance with the requirements set out in the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First: National Guidance for the Protection and Welfare of Children, 2017. The service manager must update the statement of purpose to ensure it accurately describes the day-to-day operations of the centre and that is fully compliant with the criteria outlined in	The quality auditor will ensure that the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First: National Guidance for the Protection and Welfare of Children, 2017 continue to advise the organisation's P&P document and subsequent practice. The centre manager will ensure that any updates are communicated to the team via team meetings. Next discussion will occur on May 18th 2020. The statement of purpose was updated on the 14.04.2020 and now includes the day-to-day operations of the centre.	Senior management and the centre manager will ensure that the centre is operating in compliance with legislation and standards. Any updates will be discussed with the team during team meeting and individually during supervision. The service manager and centre manager will regularly review the centres statement of purpose to ensure that it is fully compliant with the National Standards for Children's Residential Centres, 2018

	the National Standards for Children's Residential Centres, 2018 (HIQA). The registered provider must ensure that external governance processes are comprehensively assessing and responding to deficits in practice so that good quality care and support is provided to young people.	 The service manager will visit the centre twice a month with one of these visits occurring on team meeting day. Feedback from service manager visits will be formally documented and stored appropriately. All discussions relating directly to the centre will be documented and stored accordingly. This is in place with immediate effect.	(HIQA). The service manager will ensure that these twice monthly visit occur going forward and through monitoring and oversight of centre practices will strive to ensure good quality care and support is continually provided to young people.