An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 147

Year: 2019

Inspection Report

Year:	**2019**
Name of Organisation:	**Kellsgrange Residential Services**
Registered Capacity:	**1 young person**
Type of Inspection:	**9th & 10th December 2019**
Registration Status:	**Special Arrangement Registered with attached conditions from 31st May 2019 to 31st May 2022**
Inspection Team:	**Paschal McMahon** **Joanne Cogley**
Date Report Issued:	**29th April 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 monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration on the 25th January 2019. At the time of this inspection the centre were in their second registration and were in year one of the cycle. The centre was registered as a special arrangement without attached conditions from 31st May 2019 to 31st May 2022.

The centre's purpose and function stated that it was a special arrangement for single occupancy for a young person aged between thirteen to seventeen years on admission. Their model of care was described as being built on a relationship based model which re-affirms the importance of working relationships between social care workers and young people within a contemporary perspective.

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 centre manager, registered provider and the relevant social work department on the 28th January 2020. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 13th February 2020. This was not deemed to be satisfactory and the inspection service did not receive evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre was not in compliance 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: 147 with attached conditions to the centres registration under Part VIII, Article 61, (6) (a) (I) of the Child Care Act 1991: There must be no further admissions of a young person to this centre from the 31st of May 2019 to the 31st of May 2022 with a review date of the 31st May 2020 for attached conditions.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The centre had a number of relevant child protection policies and procedures in place which were compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017. These included policies and procedures on safe practice, working alone and responding to disclosures of allegations of abuse. The centre had recently developed a policy on young people's access to electronic communication to safeguard the young people from possible exploitation on the internet and social media. The centre also had a bullying and harassment policy in place. Inspectors found that some policies and procedures needed to be reviewed and updated to be compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017.

The inspectors found from a review of personnel files that the centre's recruitment practices were unsafe and did not minimise the risk of persons who were unsuitable to work with young people being employed in the centre. Four personnel files reviewed showed that safe recruitment and vetting procedures had not been followed. The most serious breaches found were in relation to staff members taking up their duties prior to the centre receiving Garda/police clearances and the required three written references. In some cases the references on file were received after the staff members took up their post. Inspectors also found that verbal reference checks were not always evident on files; there were gaps in an employee CV and no evidence of employee risk assessments being conducted when required. These recruitment practices were in breach of the organisation's recruitment policy and the statutory obligations on employers in relation to Garda vetting requirements for persons working with children as set out in the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016. The director of the service must ensure that all personnel files are reviewed without delay to ensure all staff are appropriately vetted. In addition, the director must ensure that the centre's staff recruitment practices are more robust ensuring that strict vetting procedures are adhered to going forward.

The centre had an appropriate child safeguarding statement in place which was being reviewed at the time of inspection. Post inspection the inspectors were provided with

a letter of compliance confirming that the child safeguarding statement had been reviewed and approved by the Tusla Child Safeguarding Statement Compliance Unit. Staff that were interviewed were aware of the appropriate procedures for receiving a disclosure of abuse from a young person and the requirement to submit child protection welfare report forms on the Tusla portal. However, some staff were unclear of their role as a mandated person and the legal obligations under the Children First Act 2015 that the responsibility to report mandated concerns rested with them and not with the designated liaison person. While all staff had completed training in the Tusla E-Learning module: Introduction to Children First not all staff had received child protection training from the organisation. The inspectors found in interviews that not all staff were familiar with the centres child protection policies and the risks outlined in the centres child safeguarding statement. The director informed inspectors that child protection training was scheduled in January 2020. Inspectors recommend that the centres child protection policies, child safeguarding statement and the role of the mandated person are reviewed during this training.

The young person's social worker and significant family members stated in interviews that they were kept informed of the risks associated with the young person and strategies in place to manage these risks. A psychotherapist attached to the organisation provided clinical guidance to the staff team on safeguarding in relation to the young person and the risks the young person presented with, as well as providing therapeutic support to the young person's family.

During the period under review there had been one recorded child protection concern on file which had been reported to Tusla. Inspectors found that following this incident that risk assessments had been carried out and a number of safeguarding measures were put in place. Inspectors found limited evidence on file that work was undertaken with the young person following this incident in regards to keeping themselves safe. Inspectors were informed that two staff members had recently received training in safeguarding programmes and were due to undertake further work with the young person. The centre had agreed arrangements in place to inform parents of allegations of abuse.

The centre did not have a policy on protected disclosures and inspectors were informed at the time of inspection that the organisation was in the process of developing a policy.

Standard 3.2

The centre had a policy on managing behaviour which referred to a range of approaches and techniques used in the centre to assist young people develop positive ways of dealing with their experiences of everyday life. All permanent staff members were trained in an approved model of behaviour management and there was evidence of regular refresher training being completed. Staff in interview outlined the centres approaches to behaviour management. One of these approaches was the use of a behaviour modification chart which offered financial incentives to encourage the young person to behave appropriately and engage in the centres programme. This included showing respect for staff and following house rules. In addition to this the young person was being financially rewarded for attending psychotherapy appointments and key working sessions. Inspectors recommend that this is reviewed in terms of its effectiveness and the learning for the young person.

The young person had an individual crisis management plan (ICMP) on file which outlined intervention strategies to be used should the young person engage in challenging behaviours. Individual risk assessments had been carried out and there were risk management plans in place. The centres behaviour management policy stated that the ICMP should give clear guidance to staff regarding what interventions are acceptable including whether or not physical intervention is appropriate for a young person. However, all those interviewed during the inspection told inspectors that physical intervention was not considered an option as there was a "no restraint" policy in operation. The young person's ICMP did not specify physical restraint as an intervention or any alternate strategy to be utilised in response to the possibility of the young person placing themselves or others at risk of harm. The centre management must review the centres behaviour management policy in regards to the use of physical restraint and satisfy themselves that staff understand the policy. The young person's ICMP must also be amended in line with this to reflect the centres planned approaches to managing challenging behaviour.

Inspectors noted from a review of incident records that life space interviews were carried out following incidents in an effort to assist the young person to manage their behaviour and change behaviour patterns. Key work records viewed showed that individual work was carried out with the young person to assist them in managing their behaviour. An inspector met with the young person residing in the centre and they said that staff supported them in managing their behaviour and treated them with respect. The placing social worker and a significant family member were satisfied that the young person's behaviour was well managed. They both stated that

they felt that the positive relationships staff had developed with the young person was a significant factor in the management and improvement in the young person's behaviour since their admission.

Staff in interview had a good understanding of the young person needs and it was evident that the young person had built relationships with staff and had made progress during their time in the centre. Staff were provided with clinical guidance from the organisations psychotherapist to assist them in understanding the underlying causes of behaviour and presenting issues. The social worker for the young person had provided sufficient pre-admission referral information to the centre.

The centre did not have a policy on the use of restrictive practices. As previously highlighted there was a lack of clarity as to whether physical restraint was a permitted restrictive practice and this needs to be clarified. During interviews with staff, inspectors were informed that there was a practice of locking the kitchen door at night. Staff were unclear as to the rationale behind this and there was no evidence that this had been risk assessed or reviewed. The centre management accepted that there was no reason for the kitchen to be locked and stated that this practice would cease. The centre management should ensure that all restrictive practices are risk assessed, reviewed and put in place for the shortest time possible

The centre did not have a formal auditing system that included an audit of the sanctions and rewards and behaviour management practices in place. The director informed inspectors that the organisation were in the process of implementing a formal auditing system which will address this deficit.

Standard 3.3

From a review of questionnaires and interviews with staff it was evident that there was an open culture whereby staff could raise concerns and identify areas of improvement. Staff conducted a debrief following each shift and in interview were able to give examples of challenging each other's practice and approaches in working with the young person. The young person in interview spoke positively about the management and staff stating that they liked living in the centre and they could speak to them about issues or concerns.

The social worker for the young person along with a significant family member told inspectors that they were in regular contact with the centre and were very satisfied with the care the young person was receiving. At the time of inspection there were no

formal mechanisms in place for them to provide feedback on the care being provided and to identify areas of improvement. The inspectors recommend that management implement a formal mechanism for parents and social workers to provide feedback on the care being provided by the centre for learning and quality improvement purposes.

There was a policy on the notification of significant events. Inspectors found from reviewing files that significant events were notified promptly to the appropriate persons and this was confirmed by the placing social worker.

The centre was part of a significant event review group that met monthly and reviewed incidents for the organisations two centres. Inspectors were informed that significant events were also reviewed at team meetings which took place fortnightly. Inspectors reviewed the significant event report group minutes on file and found that they contained limited information. The minutes viewed recorded an overview of decisions made following a review of incidents, they did not however contain any analysis of causes of behaviours and there was no evidence of the young person's ICMP being reviewed following incidents. There was also no evidence in the significant event review group and staff meeting minutes of an analysis of learning from significant incidents being communicated to the staff team identifying trends and patterns to inform and improve staff practice. The centre management must ensure that learning from the significant event report group and incident reviews is communicated to the staff team to inform the development of best practice.

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 3.2** **Standard 3.3**
Practices did not meet the required standard	**Standard 3.1**

Actions required

- The registered provider must ensure that the centres child protection policies are reviewed and updated in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017.

- The registered provider must provide a plan to inspectors that will address all deficits in vetting.
- The registered provider must ensure that the centre's staff recruitment practices are more robust ensuring that strict vetting procedures are adhered to in accordance with the organisations recruitment policy and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016.
- The registered provider must develop and implement a policy and procedure on protected disclosures.
- The centre management must ensure that individual work is undertaken with the young person in regards to keeping themselves safe.
- The centre management must review the centres behaviour management policy in regards to the use of physical restraint and satisfy themselves that staff understand the policy. The young person's ICMP must also be amended in line with this to reflect the centres planned approaches to managing challenging behaviour.
- The registered provider must ensure that an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.
- The registered provider must implement a formal mechanism for parents and social workers to provide feedback on the care being provided by the centre for learning and quality improvement purposes.
- The centre management must ensure that learning from the organisations significant event report group and internal incident reviews is communicated to the staff team to inform the development of best practice.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

Inspectors reviewed the centres policies and procedures and found that they required updating in accordance with the National Standards for Children's Residential Centres, 2018 (HIQA). Staff in interview did not demonstrate a clear understanding of the centres policies and procedures and relevant legislation. There was no evidence in team meetings or other forums that the registered provider was conducting policy reviews with the centre manager and staff team. The registered provider must ensure that staff are aware of the centres policies and procedures. The inspectors recommend that systems should also be put in place for the on-going

review of policies to ensure they are appropriate and meet the needs of the young people.

Standard 5.2

The previous inspection of the centre found that the governance of the centre was not robust enough. Poor systems for oversight and governance were identified which resulted in the inability of the centre to operate in accordance with its own policies and procedures. The inspectors found in this inspection that this remained the case and that governance was poor**.** This was evident to the inspectors following interviews, a review of administrative files, personnel files and the issues identified in this report. The director acknowledged in interview that one of the main issues that needed to be addressed was the need for clarity in regards to the roles of the director and the centre manager in the operation of the centre. This issue was also highlighted in an external audit conducted the week prior to inspection in which governance was identified as an area that required improvement. The audit action plan recommended that the roles of the director and centre manager are more clearly defined to ensure appropriate care practices in accordance with statutory requirements, national standards and centre policy. The director informed inspectors that in response to this recommendation they had begun the process of reviewing the governance in the centre and the completion date for this review was January 2020.

The director stated that the centre had a service level agreement in place and a bi annual report was provided to their funding body.

The centre had policies and procedures in place for the identification, assessment and management of risk associated with the young person's care. The staff in the centre were familiar with the young person, were alert to signs of potential risk of harm and had risk management plans in place. There were suitable arrangements in place to provide 'out of hours' on-call support to staff to manage adverse and significant incidents and risks in the centre. The centre did not have risk registers in place to account for centre specific and corporate risks and these need to be developed to comply with the National Standards for Children's Residential Centres, 2018 (HIQA).

Inspectors found that there had been tasks delegated to the two social care leaders when the manager was on annual leave and the director had assumed responsibility for managing the centre. The centre did not maintain a formal written record of these occasions when the manager delegated some or all of their duties to another

appropriately qualified staff member. The manager must ensure that a delegation record is maintained to comply with the standards.

Standard 5.3

The centre had a statement of purpose and function which described the aims and objectives of the service. The primary aim of the centre was to provide a high quality of care within a child centred, homely and safe setting. The placing social worker and a significant family member were satisfied that these aims were being met and spoke highly of the quality of care provided to the young person.

The statement of purpose did not include information on the management and staff employed in the centre and needed to be amended to reflect this. The statement of purpose stated that the centre operated a "relationship model of care". The inspectors found from interviews with the manager and staff that they did not demonstrate a clear knowledge of the model of care and were unable to identify the theoretical approaches the model was based on or its application in practice. The director must ensure that management and staff have a working knowledge of the centres model of care and its application in practice within the delivery of care to young people.

The statement of purpose had been reviewed as required in the previous twelve months and was accessible to parents, social workers and young people in information booklets which they were given on or prior to admission.

Standard 5.4

There was evidence that the centre manager was monitoring the quality of care in the centre through their monitoring of records, observation of staff practice and contact with the young person. The manager reported to the director who held monthly meetings with the manager and social care leaders. Inspectors noted that the manager was receiving external supervision and did not receive formal supervision from the director. The director and the manager did however meet on a monthly basis to review operational issues and minutes of these meetings containing action plans were recorded by the manager. The inspectors recommend that these meetings are adapted as formal supervision sessions and recorded by the director to ensure that there is evidence of the manager's accountability and oversight of the quality of care in the centre.

The director had regular contact with the manager. They visited the centre and met with staff and the young person, attended staff meetings and signed records occasionally. The manager provided internal monitoring reports to the director but the director had no formal auditing system in place. As previously highlighted the centre had employed external auditors who conducted an audit prior to the inspection and highlighted the need for improved oversight and governance. In response to this the director stated that the governance was under review and they had plans to introduce new auditing systems. The director must ensure that they implement an auditing system to assess the safety and quality of care provided in the centre in accordance with the National Standards for Children's Residential Centres, 2018 (HIQA).

There was evidence that the young person's placement plans, key working sessions, risk assessments and relationships with staff were discussed to inform practice and achieve better outcomes. A psychotherapist attached to the organisation provided clinical guidance to the staff team on safeguarding in relation to the young person and the risks the young person presented with as well as providing therapeutic support to the young person's family.

The centre had a complaints policy in place which needed to be revised and updated. There were no recorded complaints on file in the period under review. However, inspectors found issues on centre records which could be constituted as complaints which were not recorded in the complaints register. For example, in team meeting records it was recorded that the young person made a complaint about their social worker and on another occasion they made a complaint seeking more free time. These issues were not recorded as complaints and there was no record of a resolution process being followed. The requirement for the complaints policy to be reviewed was also an issue identified in the external auditors report. The auditors recommended that the term "informal complaint" is no longer used and that all complaints are processed and recorded as complaints and the severity of the complaint should determine the response from the centre. They also recommended that the centres complaint policy is updated to include the Tusla's complaints procedure 'Tell Us' outlining how children could make a complaint about any aspect of Tusla's services. Inspectors were informed during inspection that the centre was in the process of updating its complaints policy to incorporate these recommendations.

The director stated that they were aware of the requirement for the registered provider to conduct an annual review of compliance and this will be incorporated in the new governance system.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 5.2** **Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**Standard 5 .1**

Actions required

- The registered proprietor must ensure that the centres policies and procedures are reviewed and updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA).
- The registered provider must ensure that staff are aware of the centres policies and procedures.
- The registered provider must ensure the process of reviewing and improving the governance in the centre is completed by January 2020.
- The registered provider must ensure that risk registers are put in place to account for centre specific and corporate risks.
- The centre manager must ensure that a delegation record is kept when they delegate duties to other qualified staff members.
- The centre manager must amend the statement of purpose to include information relating to the management and staff employed in the centre.
- The registered provider must ensure that management and staff have a working knowledge of the centres model of care and its application in practice within the delivery of care to young people.
- The registered provider must ensure that they implement an auditing system to assess the safety and quality of care provided in the centre in accordance with the National Standards for Children's Residential Centres, 2018 (HIQA).
- The registered provider must ensure that the centres complaints policy is revised and updated.
- The registered provider must ensure that the external audit recommendations are implemented within the allocated time frames.

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 centres child protection policies are reviewed and updated in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017.	Tusla's Children first self-assessment tool is in use by managers since February 2020. Child protection register is in place. Re-induction of all staff underway which includes child protection and e -training completed again by all staff. We are working on an integrative auditing and recording folder for all the above. To be completed by May 2020.	To be reviewed monthly in manager/director audit.
	The registered provider must provide a plan to inspectors that will address all deficits in vetting.	In place since February 2020. One person is now responsible for the process in its entirety and the responsibility lies with them to ensure all measures are accomplished before the file is put forward for induction.	Managers to be responsible for checking all information/verifications are finalised before a new individual starts induction. Director to also verify files are in order before commencement of employment. Check sheet is currently ready for new files to verify all individuals responsible have authenticated such.

	The registered provider must ensure that the centre's staff recruitment practices are more robust ensuring that strict vetting procedures are adhered to in accordance with the organisations recruitment policy and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016.	In place since February 2020. One person is now responsible for the process in its entirety and the responsibility lies with them to ensure all measures are accomplished before the file is put forward for induction. Interview notes to be kept on personnel files from April 2020 including all information pertinent to the process.	Managers to be responsible for checking all information/verifications are finalised before a new individual starts induction. Director to also verify files are in order before commencement of employment. Check sheet is currently ready for new files to verify all individuals responsible have authenticated such. Check sheet to include whether interview information is present.
	The registered provider must develop and implement a policy and procedure on protected disclosures.	This policy is in place and is an element of our new induction process which determines if it's understood and unambiguous. It has also been included in our new policies and procedures. We have a designated person and the details of such are displayed in the office for staff. The policy was discussed with the team in a staff meeting and recorded as such.	The manager will be responsible for recording and then escalating any information pertaining to such to the director who will then take over the process of engagement with the designated person/Tusla to resolve the issue in a collaborative manner.
	The centre management must ensure that individual work is undertaken with the young person in regards to keeping	Implemented into keywork from Keywork Planning Meeting and recorded. Introduction of *Significant Conversations*	Review in keywork meetings- monthly, to ensure that this programme is accessible/available/undertaken and

	themselves safe.	and recording of same. '*Lockers Programme'* to be revisited re: online safety. This is an on-going piece of work with the young person and will continue to be so as long as their care plan requires it.	revisited as appropriate. Monthly manager/director audit to oversee keywork that is planned. There is a new behaviour management process for recognising behaviours in need of attention this will also help the process of targeted keywork
	The centre management must review the centres behaviour management policy in regards to the use of physical restraint and satisfy themselves that staff understand the policy. The young person's ICMP must also be amended in line with this to reflect the centres planned approaches to managing challenging behaviour.	Being undertaken currently. Behaviour management plans in use in all files since December 2019. Discussion at staff meeting in April 2020 in relation to restraint policy. All ICMPs are reflective of same.	All ICMPs to be reflective of our no restraint policy. Manager to be responsible for auditing of these documents. Director to be responsible for auditing the manager's assessment. Director is responsible for implementing the changes needed to the current behaviour management techniques and policy. By June 2020 we will have a majority of same completed and will then consider the next step we take as a team to improve our service. We have implemented a new process of recording and managing new behaviours as of April 2020 also.

	The registered provider must ensure that an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.	New behaviour management process in place since April 3rd 2020. It records the behaviour and dictates a plan to remedy such. This includes keywork and therapeutic input from our psychotherapist within a timeframe for review of efficacy.	Auditing of this process is monthly in manager/director audit. Weekly manager reports to director will also inform of current behaviour plans in operation and what has been achieved for same/continuing work.
	The registered provider must implement a formal mechanism for parents and social workers to provide feedback on the care being provided by the centre for learning and quality improvement purposes	In Place.	To be audited monthly by the manager/director and deficits remedied. Feedback then given on this process to the family/social workers.
	The centre management must ensure that learning from the organisations significant event report group and internal incident reviews is communicated to the staff team to inform the development of best practice.	SEN's are reviewed thoroughly at Team Meetings. This review will now include a section on '*Management Feedback from SERG Meetings*'. Management will ensure to record all information communicated, and monitor learning outcomes in order to promote & inform the development of best practice. Date: Began January 2020 and to continue monthly hereafter.	To be implemented and overseen by the manager. Team meeting minutes to be audited by the director monthly.

5	The registered proprietor must ensure that the centres policies and procedures are reviewed and updated in line with the National Standards for Children's Residential Centres 2018(HIQA).	Completed.	To be reviewed as part of governance auditing monthly and used in staff meetings biweekly for staff instruction.
	The registered provider must ensure that staff are aware of the centres policies and procedures.	Staff meetings have dedicated time to discussion of two policies per meeting.	Governance tool in use monthly by manager/director.
	The registered provider must ensure the process of reviewing and improving the governance in the centre is completed by January 2020.	Weekly report forwarded to director from manager and response issued. Monthly meetings address and record all governance issues.	Further governance tools in process by the director to be completed by June 2020. External company aiding this process.
	The registered provider must ensure that risk registers are put in place to account for centre specific and corporate risks.	In place.	Audited monthly also by director and manager and outcomes assessed and responded to and recorded.
	The centre manager must ensure that a delegation record is kept when they delegate duties to other qualified staff	Records of delegated duties were kept within the House Managers File. An individual file is now shared between	Delegation record subject to monthly auditing by manager and director. New disciplinary process to address failure to

	members.	Management and qualified staff members. This file is reviewed by the Managing Director & Management to ensure duties are completed and staff are supported throughout their professional development. Introduced officially during February Management Meeting, February 13th 2020	achieve objectives outlined.
	The centre manager must amend the statement of purpose to include information relating to the management and staff employed in the centre.	Completed.	To be updated yearly by the manager. Endorsed by the director
	The registered provider must ensure that management and staff have a working knowledge of the centres model of care and its application in practice within the delivery of care to young people.	Work being undertaken currently to be completed by June 2020. An external consultant, the organisations psychotherapist along with the director are devising a training manual for staff in relation to the model of care. Biweekly staff meeting taking place to have an integrative approach to this entire process.	Handbook is being developed by the staff team. The induction of new staff includes training in our model of care with the organisations psychotherapist. They will be subject to on-going appraisal of their knowledge of such with periodic exams on same at the discretion of the manager. Deficits in knowledge will then be

			addressed by the director with supports and training
	The director must ensure that they implement an auditing system to assess the safety and quality of care provided in the centre in accordance with the National Standards for Children's Residential Centres, 2018(HIQA).	Monthly audits/weekly reports in conjunction with the manager/director undertaken. Feedback given to the manager/team and direction given by director in relation to quality of care. Monthly meetings with team, management and manager records governance dialogue.	System in place to be further developed with the aid of Social Care Training Ireland by June 2020. Governance/auditing training for staff is part of this process.
	The registered provider must ensure that the centres complaints policy is revised and updated.	Deputy manager in another of the organisations centres is tasked with developing a tool to analyse and monitor complaints. To be completed by May 2020.	Director to audit the complaints log monthly and take responsibility to see the process through to fruition.
	The registered provider must ensure that the external audit recommendations are implemented within the allocated time frames.	Direction given to manager April 3rd 2020 to utilise any existing reports immediately	Director will be responsible for the implementation of further auditing reports by external monitors.