An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 102

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Positive Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**18th ,19th and 25th May 2021**
Registration Status:	**Registered from the 21st May 2019 to the 21st May 2022**
Inspection Team:	**Paschal McMahon** **Linda Mc Guinness**
Date Report Issued:	**15th October 2021**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in 2011. At the time of this inspection the centre was in their fourth registration and in year two of the cycle. The centre was registered without attached conditions from 21st May 2019 to 21st May 2022.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was relationship based and had four pillars: entry; stabilise and plan; support and relationship building; and exit. The centre had an emphasis on attachment theory while focusing on the development of relationships with the young people. There were three young people resident in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.2, 3.3
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1,6.4

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

At the time of this inspection the centre was registered without conditions from the 21st May 2019 to the 21st May 2022. A draft inspection report was issued to the registered provider, senior management and centre manager on the 17th August 2021 and to the relevant social work departments on the same date. 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 26th August 2021. After further communication with the regional manager in respect of the CAPA, it was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the 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: 102 without attached conditions from the 21st May 2019 to the 21st May 2022 pursuant to Part VIII, 1991 Child Care Act.

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.

At the time of inspection two of the three young people had up-to-date care plans in line with regulatory requirements. A third young person in the centre was placed under derogation to the statement of purpose as they were under 13 years of age. Inspectors found that a child in care review had taken place in September 2020 after which the centre received a care plan. There is a requirement under 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 to hold monthly child in care statutory review meetings. This was also a requirement of the continued approval for derogation. Inspectors found that these statutory reviews were not taking place in line with these requirements. Only three of the required subsequent review meetings had taken place and no updated care plan was provided. While there was evidence that the centre manager had made repeated requests for up-to-date care plans this issue was not resolved. Inspectors found that earlier escalation of this issue within the relevant social work department should have taken place to ensure compliance with statutory requirements.

Each young person had a placement plan which outlined the current issues, individual needs and the supports required to implement the goals of the care plan. These goals were reviewed regularly, and young people moved through the pillars set out in the care framework as they progressed through placement. There was evidence that the views of young people were sought through individual work/key working sessions and at young people's meetings. The placement plans also considered the views of young people's families and other relevant people where appropriate. Social workers were consulted in relation to placement plans and identifying the goals and supports required; however, one social worker told inspectors that they had asked for monthly progress reports and they did not receive an adequate response to this matter.

Inspectors found that the placement planning did not reflect the model of care and that there should be greater emphasis on utilising the model of care in the placement planning process and this was also highlighted in an internal audit. Inspectors noted that some issues such as phones/access to the internet and bullying required more attention in the placement plans.

Each young person had been supported to access external specialist supports in a timely manner. The social worker for one young person confirmed that they were awaiting dates for an assessment. The young people were linked in or waiting for several specialist services including the Child and Adolescent Mental Health Service (CAMHS), occupational therapy, Children at Risk in Ireland (CARI) and equine therapy.

Each young person had a therapeutic plan which gave insight from a clinical perspective and recommended interventions and approaches. Inspection interviews with social workers and review of records showed that the manager had to go through the regional manager to contact the psychologist. An inspector spoke with the psychologist who outlined their role in developing the therapeutic plans and the support provided to the staff team and the young people. Inspectors found that therapeutic plans had highlighted serious concerns in relation to the high risks of social media usage and phone access and these concerns were not sufficiently discussed at staff and management meetings. The inspectors recommend that there is a more effective connect between the centre and the clinical department in respect of planning for young people.

The centre manager and team reported that overall, there was effective communication with allocated social workers and this was reflected across centre records. There was however a delay in the centre reporting a child protection concern for all of the young people when an unknown young person was found to have stayed in the centre for three days and nights without staff knowledge. This issue is discussed in more detail further on in the report. Social workers confirmed that there was good day to day communication. They reported that the staff and management were working hard to meet the needs of the young people despite complex needs and presentations. This commitment to a high level of day to day care provision was evident from review of young people's files and centre records.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None Identified**
Practices met the required standard in some respects only	**2.2**
Practices did not meet the required standard	**None Identified**

Actions required

- The client services manager must ensure that they work with the supervising social work department to ensure that care planning meetings take place in line with regulations and national policy and the requirements of derogation.
- The client services manager must ensure that issues of risk including access to internet and bullying have a greater focus in placement planning.
- The registered provider must ensure that there is a more effective connect between the centre and the clinical department in respect of planning for young people.

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1- Each child . Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

The centre had relevant child protection policies and procedures in place which were compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the National Standards for Children's Residential Centres, 2018 (HIQA). The centre had an up-to-date child protection policy and a child safeguarding statement with written confirmation from the Tusla Child Safeguarding Statement Compliance Unit that the statement met the required standard.

There was an anti-bullying policy in place and management and staff described a no tolerance approach to bullying in the centre. However, in practice at the time of inspection there were a number of incidents of young people targeting or excluding each other and this required a more robust response. Staff interviewed stated that they felt that they required more training in respect of this issue.

Training records provided to inspectors showed that all staff had received child protection training provided by the organisation as part of their induction along with training in the Tusla E-Learning module: Introduction to Children First.
It was evident from team meeting records that child protection and safeguarding was a standing agenda item. Notwithstanding this, inspectors found that there was a failure to protect young people and a delay in the reporting a child protection concern for all young people when an unknown young person was found to have stayed in the centre for three days and nights without staff knowledge. This incident should have warranted prompt reporting to Tusla by mandated staff in line with Children First, National Guidance for the Protection and Welfare of Children, 2017. One social worker reported that they were not informed about this issue for a number of days despite being in contact with the centre in the intervening period. A social worker told inspectors that they had to ask for a child protection notification to be made through the Tusla Portal as the centre initially felt that one was not warranted.

Supervising social workers and the centre informed inspectors that there were arrangements were in place for parents and guardians to be informed of any incident or allegation of abuse.

Inspectors found evidence that preadmission risk assessments had been carried out prior to the young people's admission to identify and address areas of vulnerability and risk management plans were developed when necessary. There was evidence on care files and key work records of individual work being undertaken with the young people in regard to keeping themselves safe. All the young people told inspectors that they felt safe in the centre and identified staff members they could speak with if they had a concern.

The centre had a whistleblowing policy which outlined the procedure for making a protected disclosure enabling members of staff to raise concerns or disclose information of wrongdoing or malpractice.

Standard 3.2- Each child experiences care and support that promotes positive behaviour.

The inspectors found from interviews and a review of care files that there was a positive approach to managing behaviour. There was evidence of an open culture and staff stated they could raise concerns or report incidents.

The team were familiar with behaviour management policies in place. All staff were trained in the approved model of behaviour management in use in the centre and regular refresher training was completed within the required timeframes. Each young person had an individual risk management plan (ICMP) which outlined safety concerns, current risks, preventative measures, triggers and de-escalation strategies. There was evidence that these were being implemented effectively by staff and were reviewed regularly.

When significant events or incidents took place there was evidence that the staff team followed up appropriately with individual work/ key working. They made efforts to conduct life space interviews in line with the model of behaviour management and were creative where young people did not have a capacity to engage.

Inspectors found from a review of centre records and interviews with staff that the team did not rely on sanctions or negative consequences to manage difficult behaviour and that positive behaviour was encouraged and rewarded. Staff described a positive approach to behaviour management which was guided by policy and implemented in practice.

There was evidence that staff were focused on understanding the underlying causes of challenging behaviour. However, inspectors found reference to three different types of attachment patterns noted across different documents in one young person's care file resulting in a lack of clarity. Social workers informed inspectors that keyworkers do not generally attend multi-disciplinary planning meetings for young people unless specifically requested. Their attendance at these meetings would ensure greater clarity about analysis of young people's presenting issues, expectations and approaches to behaviour by the team. This would facilitate a more consistent approach to behaviour management.

Key working and other supports had been provided to young people struggling with the restrictions in place due to the Covid-19 pandemic. A review of key working records showed that the team were working with young people to encourage

acceptance of difference and diversity. Young people's meetings also evidenced a focus on rights of everyone living and working in the centre.

Approaches to behaviour management were reviewed through team meetings and through the organisation's significant event review group. New auditors had been appointed throughout the organisation and review of behaviour management formed part of this process. The centre manager's governance report included an analysis of the effectiveness of consequences and rewards. The regional manager and the client services manager had oversight of all significant events. Review of centre records showed that risk management plans were in place for each young person. Inspectors found that some deficits relating to risk management plans were not highlighted through oversight or auditing by senior management and this is addressed under standard 5.2 of this report.

Inspectors found some aspects of behaviour management required more focus and the attention of senior management in consultation with social workers and the clinical team. One social worker stated that they had to ask on a number of occasions for a more robust response to a negative dynamic between two young people. They felt that the issue was now being taken seriously but that it could have been responded to sooner. Another social worker felt that more work needed to take place with their young person about the impact of their negative behaviour and respecting the rights of others.

Inspectors and social workers had concerns about young people absconding from the centre on two occasions without this being known to staff, and another young person being in the centre without staff knowledge for three days.

The centre had a written policy on the use of restrictive procedures. At the time of the inspection there were a number of permitted restrictive procedures in place. There was evidence that restrictive procedures were subject to risk assessments and were regularly reviewed. However, inspectors noted that there was a reluctance or inability to implement some restrictive measures such as removing or restricting mobile phones/access to internet and the centre looked to social work departments to make these decisions. Two young people had unsupervised access to the internet despite child protection and welfare concerns arising relating to their activities online. While there was evidence that the team promoted safe use of the internet through individual work and key working it was an issue which required a more robust response to ensure the safety and welfare of young people.

Physical restraints had taken place for one young person in the year prior to inspection. Inspectors found that these had reduced in frequency and duration and continued to do so. The supervising social worker told inspectors that they felt there were initially some situations where staff did not intervene early enough but that this issue was resolved following discussions with management. Inspectors were satisfied that there were mechanisms in place for the monitoring and oversight of the use restraint in the centre. There was appropriate escalation, and review of restraints to analyse triggers, trends or emerging patterns however the register of physical interventions did not record the duration of restraints as required.

Standard 3.3 - Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Inspectors were satisfied that an open culture was promoted. Staff expressed confidence in centre management who they said were supportive and approachable. Inspectors found that young people's meetings were held regularly and they were supported by staff and managers to express their views and have their voices heard. There was evidence that that they were aware of the centres complaints process and were supported to use it if they were dissatisfied with aspects of care being provided. Complaints were reviewed for emerging trends or patterns.

There were systems in place including surveys which showed that the centre consulted with and sought feedback from parents, social workers and other relevant professionals to determine their views on the quality of care being provided. There was evidence of regular contact with families if this was agreed through the care planning process. Social workers interviewed stated that they had regular and consistent communication with centre management.

The centre had a policy on the notification, management and review of incidents. As mentioned previously, inspectors were informed by the allocated social workers that in general incidents were reported promptly via phone and e-mail but that there was a delay in informing them about the presence of another young person in the centre for three days. This was not initially reported in line with Children First, National Guidance for the Protection and Welfare of Children 2017. There was evidence of oversight and commentary by the manager and regional manager on incident reports relating to this specific incident. However, it is the finding of inspectors that the review of this incident was inadequate. Social workers informed inspectors that it was difficult to see how this could happen in a small house and not be known to staff. This raised concerns about the staff supervision of and contact with young people.

They informed inspectors they felt that there were indicators that were missed and inspectors concur with this assessment

Inspectors did not have access to all records in relation to the investigation as they were not provided with copies of staff interviews. The records that were provided included some inaccuracies and errors. This included inaccurate records of times young people were asleep and the times that they left the centre. Not enough weight was given to presenting behaviours or the concerns of a parent. The outcome of the review did not adequately report on all risks taking the age of young people into consideration. These were not picked up by senior management review of the records or adequately addressed in the investigation.

Inspectors found that a significant review group review meeting did not take place after two very young people left the centre unknown to staff in the middle of the night in August 2021. This was a serious incident that should have warranted such a review.

Inspectors were informed that incidents that took place were discussed at team meetings and in staff supervision. Inspectors could see that learning was communicated to the staff team by management following review of incidents and analysis of restraints. Inspectors found however, that the records of team meetings did not adequately represent the discussions and decision making processes and did not evidence the voice of the staff team. This was also highlighted in an internal audit of the service.

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

Actions required

- The registered provider must ensure that all staff are aware of their role as mandated persons under Children First; National Guidance for the Protection

and Welfare of Children to report child protection concerns in a timely manner in all instances.

- The centre manager must ensure that appropriate safeguarding measures are implemented in relation to young people's phone and internet use.
- The registered provider must ensure that all serious incidents are reviewed at a SERG review.
- The registered provider must ensure that records of team meetings adequately represent the discussions and decision making processes and evidence the voice of the staff team.

Regulation 5: Care Practice s 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.

There was evidence of good leadership in the centre. The social care manager was with the organisation since 2014 and had held a number of other posts in the organisation. They commenced in their current role in August 2020 and the team stated that they provided stable management and good leadership with the support of the deputy manager. There were two appropriately qualified and experienced social care leaders in post who had worked in the centre for over eight and three years.

Inspectors found from a review of the team meetings, daily logs and young people's planning documents that there was some evidence of a culture of learning where incidents were reviewed and analysed. However, there were occasions as discussed previously above when a most robust response was required. Also, some issues in respect of deployment of staff arose during the inspection which raised concerns about quality and safety. These are discussed further under section 6.1 of this report.

There were clearly defined governance arrangements in place and all staff were aware of the management structure and individual roles and responsibilities. There was a recently appointed deputy CEO in place and they recently visited the centre and met with the centre manager and the regional manager. The regional manager expressed confidence in the centre management and this was reflected in the audits of the

centre viewed by inspectors. Staff reported that the regional manager visited the centre usually on a monthly basis. They had conducted audits of the service and had met with young people and staff.

A new system of quality assurance auditing was recently implemented which was aligned to the national standards. These audits identified areas of non-compliance and an action plan was created and followed up in a timely manner. However, some deficits highlighted during this inspection were not identified in those audits. For example, it was not noted that records of night checks were not adequately recorded, and it could not be determined if they were visual checks.

There was a service level agreement in place with the Tusla, Child and Family Agency and the client services manager was in regular contact with relevant people and attended meetings.

The centres policies and procedures were updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence of an on-going review of policies and procedures by both the organisation and by external consultants. Staff had received refresher training in the centres policies and procedures in late 2020.

There was a risk management framework in place for the identification assessment and management of risk. Staff had a good working knowledge of the system and risk was an agenda item at team and management meetings. A daily risk review and governance report was completed by regional managers. Current and on-going risks were rated and tracked by the centre manager and the regional manager through their oversight of records and audits. Inspectors found that a review was required in respect of scoring and determining thresholds of risk. Some areas of risk such as internet access were scored too low considering the possible impact on young people. One social worker and guardian ad litem felt that risks relating to working alone with one young person outside the centre were not given enough consideration.

Inspectors found that risk management planning following serious incidents required review. The door alarms were recorded as a protective measure on risk management plans however, inspectors found that they were not working for an extended period of time while parts were sourced. Risk management plans indicated that checks were required at night to ensure that young people were in their rooms and that no other people were in the centre. Checks were only to remain in place if young people were awake at night. This system did not factor into account the possibility of young

people waking up and communicating with each other electronically after staff went asleep as they frequently had mobile phones in their rooms.

The expectation was that the staff on shift would provide live night cover when risk management plans identified risks. This meant that that they would be awake for 20 hours out of a 24 hour shift. This is not safe practice. There was no risk assessment relating to the possible impact of this on young people or staff. Social workers who were interviewed during inspection were unaware that this cover was not provided by specific live night staff.

Inspectors found that there were procedures in place for the management of the Covid-19 virus. An outbreak in the centre had been well managed. There were adequate supplies of anti-bacterial products and personal protective equipment. There was an increased cleaning regime in place and visitors to the centre were carefully managed.

The centre had a management structure appropriate to its size and purpose and function. There were arrangements in place to provide cover when the manager took periods of leave. Where managerial responsibilities were delegated to other staff members a formal record of this was in place as required. There were adequate on call arrangements in place to guide, support and direct staff out of office hours when a manager was not present on site.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None Identified**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that all live night checks are accurately recorded to record the times of checks and the presentation of young people.
- The registered provider must ensure the accuracy of all records through oversight and auditing processes.
- The registered provider must ensure that risk ratings are reviewed in respect of scoring and determining thresholds of risk.

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.

From a review of management meetings and audits for this centre, inspectors found that the registered provider had an appropriate focus on workforce planning. As well as the manager and deputy, the staff team was comprised of two social care leaders, seven social care workers and an unqualified social care worker who was being supported to attain a relevant qualification. At the time of inspection there was a stable team in place and eight of the staff had worked in the centre since 2018. Eight staff held social care qualifications while other staff qualifications included social work and community and youth work. There was a good balance of experience, skills and gender across the team.

Inspectors did find however that 16 different staff worked covering shifts in the centre since August 2020. With the exception of three, these people were not accounted for on the staffing list provided for inspection purposes which detailed staff who worked in or who had left the centre. Three dedicated relief staff were now available to cover all types of leave.

Review of centre rosters and clock card records found a number of instances in 2021 where staff worked back to back shifts and were in the centre for 48 hours. While this was part of a risk management plan to manage a Covid outbreak in December inspectors found that it also happened in July and September 2020 and January 2021. Also, there was evidence across rotas, clock cards and centre records that there were weeks where staff had worked significantly over their allocated hours. This included staff working up to 88 hours in one week. The registered provider must

ensure that there is a core stable staff team in place with sufficient relief cover available at all times.

From a review of the rosters provided it was established that staff in the centre were scheduled to start at 8am and work 24 hours finishing at 8am the following day. The clock card readings for staff did not reflect this as some staff were required to remain on in the centre to provide a handover to the staff coming on shift. Inspectors found that there was no built in time built into the rota for these handovers. Handovers should be used for the planning of care for young people and as a safeguarding process and there should be protected time for this built into each shift. This was not highlighted in audits of the centre which commended comprehensive handover processes. A risk assessment had been requested by staff about driving after such shifts however, there was no evidence that this took place. The practice of staff working back-to-back shifts in the organisation must stop immediately.

Inspection interviews and review of management meetings found that it was determined that the centre was overstaffed by one and staff were sent to other centres to provide cover there. This was during a period of reduced capacity when a fourth young person left the centre. No risk assessment had taken place about the impact on young people or staff and no consideration was given to using surplus staff for live night shifts. Review of supervision records, questionnaires and interviews with staff showed that the team had expressed concern and dissatisfaction about this issue. Social workers informed inspectors that they knew that night checks were taking place but did not realise that staff on shift were doing these. They concurred with inspectors that this was unsafe practice particularly in light of the demands of day to day care for one young person. There was no evidence that senior management considered this practice as a safeguarding and health and safety issue.

There was a policy and measures in place to promote staff retention and continuity of care for young people. This included an employee assistance programme, the provision of on-going training, career progression opportunities and access to healthcare. Staff exit interviews took place and information from these was included informed approaches to recruitment and retention of staff. Inspectors did not see that the dissatisfaction of staff at the shift pattern was considered as a possible issue in terms of staff retention even though most inspection questionnaires highlighted this as a significant challenge that was not sustainable. Social workers were satisfied that the organisation made every effort to ensure that there was a stable staff team to provide consistent care to young people.

There was an on-call system in place which adequately provided for support and cover during evenings and weekends. The organisation held records of on-call interactions and decisions made for review and oversight purposes.

Standard 6.4 - Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

Inspectors were satisfied that all staff working in the centre had received training and development opportunities relevant to their role in line with the requirements of legislation, standards and guidelines, and the needs of the young people. All the staff in the centre had undertaken relevant mandatory training and received timely refresher courses as required. The organisation had an on-line training portal to facilitate access to various supplementary training courses and resources were provided to source external training when required. Review of returned questionnaires confirmed that staff were provided and availed of on-going training opportunities although they did state that they required more training relating to bullying and trauma informed care.

Policies and procedures were regularly reviewed at team meetings and staff were interviewed about knowledge and application of policies during new auditing processes.

There was a policy in respect of new staff being inducted to work in the organisation and the centre. This was evidenced as having been completed on individual personnel files. Each staff member had an individual training and development plan which was reviewed in their professional supervision. The manager and regional manager had oversight of training needs in the centre and this was included in centre audits and the manager governance report.

A database was in place to record and track all training and professional development.

Staff members training records were maintained centrally by the organisations training department and on staff personnel files. Inspectors reviewed a number of personnel files during the inspection and found that the training records were up-to-date and there were training certificates on file.

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

Compliance with standards	
Practices met the required standard	**Standard 6.4**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**None Identified**

Actions required

- The registered provider must ensure that there is a core stable staff team in place with sufficient relief cover available at all times to cover all forms of leave.
- The registered provider must ensure that there is protected time for handovers in each shift for the planning of care for young people.
- The registered provider must ensure that if live night cover is required that live night staff must be rostered on duty to carry out these shifts.
- The registered provider must ensure that the practice of staff working back-to-back shifts in the organisation stops immediately.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The client services manager must ensure that they work with the supervising social work department to ensure that care planning meetings take place in line with regulations and national policy and the requirements of derogation.	The care plan referred to is now on file following escalation from the client services manager.	The 'Planning for a Young Person' Policy was updated in May 2021 to include the escalation process to be followed if a care plan has not been received.
	The client services manager must ensure that issues of risk including access to internet and bullying have a greater focus in placement planning.	There was a focus in keyworking with the young people in the centre in relation to internet safety/safety with social media and bullying. This has now been linked directly to the young people's placement plan goals.	Placement plan goals are reviewed with keyworkers and all team members in monthly supervision meetings and monthly keyworking meetings. Quality audits will ensure oversight of placement plan progress.
	The registered provider must ensure that there is a more effective connect between the centre and the clinical	The centre manager has direct access to the clinical department as and when required. In relation to clinical attendance	Clinical needs per service are reviewed as part of the weekly link in meetings and fed directly to the clinical team to ensure

	department in respect of planning for young people.	at meetings this is requested through the client services manager due to the case load of young people in the organisation.	follow up and planning for clinical supports required.
3	The registered provider must ensure that all staff are aware of their role as mandated persons under Children First; National Guidance for the Protection and Welfare of Children to report child protection concerns in a timely manner in all instances. The centre manager must ensure that appropriate safeguarding measures are implemented in relation to young people's phone and internet use. The registered provider must ensure that all serious incidents are reviewed	Refresher training was completed with the staff team in relation to their roles as mandated persons and child protection and reporting procedures In April 2021. The regional manager attended a team meeting to deliver this training. There are clear structures in place in relation to phone credit, chargers for phones and handing up phones at night-time to ensure safeguards are in place around phone and internet usage and the monitoring of same. Young people do not have access to Wi-Fi in the centre. Individual work is also completed with all young people in relation to the risks of internet and phones. SERG reviews now take place based on serious incidents as opposed to risks that	All staff members are trained in Child Protection and the role of the mandated persons and receive regular refresher training in same. Risk ratings for phone and internet usage are noted on each young person's individual IRMP (Individual risk management plan) and ratings for same are reviewed weekly in weekly link in meetings. Any escalations in risk relating to same are notified to the social worker and collective decision made in relation to removal of the phone under Child protection on a case-by-case basis. SERG reviews now take place based on serious incidents as opposed to risks that

	at a SERG review. The registered provider must ensure that records of team meetings adequately represent the discussions and decision making processes and evidence the voice of the staff team.	are only rated 15+. Team meetings are attended on an adhoc basis by regional manager and minutes reviewed by regional managers and Quality assurance auditors to ensure that the minutes reflect the discussions and decision making with the staff team involved.	are only rated 15+. Oversight from regional management and quality assurance auditors on team meetings strive to ensure that meeting minutes are reflective of inclusion and discussion with the staff team. Report writing training has been rolled out across the organisation with a focus on factual recording and report writing. Auditors now attend team meetings to deliver the feedback from audits to the staff team directly as well as a feedback meeting with the centre and regional manager.
5	The centre manager must ensure that all live night checks are accurately recorded to record the times of checks and the presentation of young people. The registered provider must ensure the accuracy of all records through oversight and auditing processes.	The daily logs now have a specific section for live night checks and recording of same. This details the times of checks, the presentation of the young person and the staff member completing the check. Regional manager and Client service manager have access to all records on our online system and daily, weekly and monthly oversight takes place. As an	The centre manager and deputy centre manager oversee and comment on the daily log. The Regional manager reviews a weekly report in relation to live night checks to ensure that the information recorded is clear and accurate from a governance and oversight perspective. Along with Regional and Client Services manager oversight, the organisation has 2 Quality Assurance Auditors who conduct regular audits of systems and records to

		organisation we identified the lack of consistency in accuracy in particular of live night checks and the level of detail required. We have since implemented a specific section in the daily logs for this purpose. Weekly reports are now generated to ensure adequate amount of detail in included and accuracy of records maintained.	ensure accuracy and additional layers of oversight. Weekly reports are generated by the Regional Manager to ensure accuracy of recording in relation to live night checks.
	The registered provider must ensure that risk ratings are reviewed in respect of scoring and determining thresholds of risk.	The risk rating has been raised in the centre with regard to internet and phone usage and individual work completed with the young people in regard to the management of same.	Weekly reports on risk ratings are reviewed through the weekly link in meeting to ensure risks are rated appropriately.
6	The registered provider must ensure that there is a core stable staff team in place with sufficient relief cover available at all times to cover all forms of leave.	The centre has now over contracted in staffing to ensure that they are not solely reliant on the usage of relief staff to cover any types of leave. There are also regular relief staff that work in the centre to ensure consistency for the young people.	The organisation has over contracted in staffing to ensure adequate staffing is available to fulfil the centres' roster requirements in line with occupancy.
	The registered provider must ensure that there is protected time for handovers in each shift for the planning	Staff rosters will now identify the handover. The shift patterns in our time management systems are now being	Shift patterns on the organisations Time management system will now reflect the time allocated for protected handover.

	of care for young people.	rectified to reflect the protected handover time.	
	The registered provider must ensure that if live night cover is required that live night staff must be rostered on duty to carry out these shifts.	An alternative roster has been developed with a live night built into it. This alternative roster will be implemented based on the assessment of risk in the centre and will continue to be in place until such time as it is agreed by all relevant stakeholders.	An alternative roster has been developed with a live night built into it. This alternative roster will be implemented based on the assessment of risk in the centre and will continue to be in place until such time as it is agreed by all relevant stakeholders.
	The registered provider must ensure that the practice of staff working back-to-back shifts in the organisation stops immediately.	Back-to-back shifts are not planned or rostered in the centre. We will endeavour to ensure that back-to-back shifts do not take place.	The organisation will endeavour to ensure that back-to-back shifts do not take place.