An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 121

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Terraglen**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced inspection**
Dates of Inspection	**10th, 11th and 12th November 2020**
Registration Status:	**Registered from 21st of October 2019 to the 21st of October 2022**
Inspection Team:	**Linda Mc Guinness** **Orla Griffin**
Date Report Issued:	**23rd December 2020**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration on the 21st of October 2016. At the time of this inspection the centre were in their second registration and were in year two of the cycle. The centre was registered without attached conditions from 21st of October 2019 to the 21st of October 2022

The centre was registered to accommodate three young people of both genders from age thirteen to seventeen on admission. Their model of care was described as a pro-social modelling approach implemented by staff through a relationship based and attachment theory informed framework. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspectors examined aspects of the following themes and standards:

Theme	Standard
4: Health, Wellbeing and Development	4.1, 4.2, 4.3
8: Use of Information	8.1, 8.2

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, 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 27th of November 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 11st of December 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 121: without attached conditions from the 21st of October 2019 to the 21st of October 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulations 10 – Health Care
Regulation 12 Provision of Food and Cooking Facilities
Regulation 23 Care Plan

Theme 4: Health, Wellbeing and Development

Standard 4.1 – The health, wellbeing and development of each child is promoted, protected and improved

Inspecotors found that the registered provider ensured that there were robust measures in place to meet the requirements of the National Standards for Children's Residential Centres, 2018 (HIQA) relating to child health and wellbeing. Staff were aware of and implemented policies and practices to promote and protect the health, safety, development and welfare of young people. There was evidence where appropriate, of regular consultation with young people and their families about their health and development.

Review of placement plans, progress reports and evaluation of outcomes evidenced that the physical and mental health of young people was prioritised. Keyworkers reviewing placement plans with the support of a case manager set goals and targets for young people relating to healthy lifestyle, the dangers of substance misuse, self care and physical and mental health amongst others. There was evidence that the staff team communicated and co-operated with other professionals in support of the implementation of health and development plans. While inspectors were not on site to observe mealtimes in the centre, review of centre records pointed to the provision of wholesome and nutritious meals and snacks. Where young people struggled with adhering to healthy and nutritious diet there was evidence of keyworking initiatives to educate them in this regard.

Records evidenced that young people often cooked for themselves and were involved in the shopping for and preparation of meals with support from the staff team. Any specialised dietary requirements were catered for. Young people and staff shared meals and staff reported that this was a positive experience.

None of the young people in the centre were preparing to leave care. However, it was evident that there was a positive focus on learning independent living skills from an early age.

Individual crisis management plans were in place for each young person. Any significant events which took place were followed with keyworking and life space interviews to support them to develop new coping skills to deal with stress and adversity. Quality assurance audits took place by the director of operations on a monthly basis to ensure that any deficits in these systems were highlighted promptly and addressed in non-compliance reports.

One young person was facilitated to attend a local support group in line with the goals of their placement plan. Review of records showed that young people were involved in decision making relating to aspects of their care which was appropriate to their age and development. Every effort was being made to ensure that an education plan for each young person promoted them achieving to their full potential.

Standard 4.2 – Each child is supported to meet any health and development needs

Inspectors found that practice to meet health and development needs was generally positive and that young people were involved in decisions about their health and wellbeing. Each young person had an up to date care plan which contained a full detailed medical history and all previous medical and psychological assessments which had taken place. There was evidence that information from pre admission risk assessments and recommendations from these assessments were incorporated into a detailed developmental audit for each young person at the outset of their placement and that this informed placement planning and future interventions in respect of physical and mental health. Young people were connected with appropriate specialist services outside the centre. Inspectors found that while guidance and direction relating to specialist interventions were communicated to the staff team and incorporated on to their care records there was a lack of evidence that there was communication with them when safety plans were being revised and updated. There was a lack of a comprehensive clearly recorded and agreed multi-disciplinary plan for supporting one young person who was presenting with which high risk behaviour.

The centre had been making efforts to obtain the immunisation records for one young person without success. The social work department informed inspectors that they would follow this up and communicate with centre management. This young person also required specialised medical treatment and it had been agreed at a child in care statutory review that funding would be sought to ensure the young person received the treatment they needed in a timely manner. This was still outstanding at the time of inspection and had been escalated within the social work department.

The centre manager and social work department must work together to ensure that the young person receives timely access to this specialist treatment.

Each young person had access to a general practitioner and all relevant information was shared with them. It was noted that the individual crisis management plans for young people did not specifically reference if there was a contra- indication to the use of physical interventions. One young person had a medical diagnosis, however, there was no evidence of consultation with medical professionals as to whether this constituted a safety issue or contra-indication to restraint. There were also other factors such as medication or self-harm which should have been assessed for inclusion on the plans.

There was a comprehensive medication management policy in place and there was evidence that implementation of this in practice was subject to regular oversight through announced and unannounced governance audits. Inspectors found that there were robust arrangements in place to prevent and manage Covid 19. The organisation's contingency plans were regularly reviewed and updated in line with National Public Health Emergency Team (NPHET) and Government guidance to ensure the safety of young people and staff members.

Standard 4.3 – Each child is provided with educational and development opportunities to maximise their individual strengths and abilities

Inspectors found that the centre placed a value on young people having access to and remaining in education in line with the requirements of the National Standards for Children's Residential Centres, 2018 (HIQA). Through review of centre records and inspection interviews it was evident that the team sought to identify the individual strengths, interests and abilities of each young person.

One young person was in full time education and arrangements were in place to ensure that they were supported to achieve their full potential. Supplementary supports were explored and provided when requested and keyworkers advocated for the young person, attended meetings and engaged with school staff where appropriate. There was good evidence of communication with the social work department about education and an agreement had been reached to share the cost of required equipment. Parents were informed and encouraged to participate in decisions relating to care and education of young people and they were encouraged to attend school meetings. There was evidence that they were updated in respect of their child's progress and were invited to attend child in care review meetings.

A second young person was not currently in a school placement contrary to legislative requirements and had missed a significant period of formal education. Review of this young person's care records showed that every effort was being made to facilitate a return to education. A school placement had been sourced however was not successful due to circumstances outside the control of the staff and young person. The management and staff team were working closely with the supervising social work department and the education welfare officer to source an appropriate educational placement. This must remain an absolute priority. The centre were providing informal educational opportunities through daily living foe this young person. The supervising social worker informed inspectors that strategy meetings would continue and that other learning and development opportunities would be explored and implemented as part of care and placement planning if mainstream school was not an option.

Review of young people's files evidenced that there was a comprehensive record of their education history, progress and achievements. Through review of care and placement plans it was evident that previous educational and psychological assessments informed approaches to care and individual supports required.

While neither of the young people in placement were approaching school leaving age, it was clear there that there was a long term vision for further education in line with one young person's own aspirations.

Compliance with Regulation	
Regulation met	**Regulation 10** **Regulation 12** **Regulation 23**

Compliance with standards	
Practices met the required standard	**Standard 4.1** **Standard 4.3**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**None identified**

Actions required

- The registered provider must ensure that there is consultation with medical professionals if required, and that each young person's individual crisis management plan specifies if there is a contra indication to restraint or not.

Regulations 17 – Records

Theme 8: Use of information

Standard 8.1 – Information is used to plan, manage and deliver child centred, safe and effective care and support

Inspectors found that there were good quality information systems in place to support the delivery of safe and effective care. There was evidence that information was collated and used to inform shared decision making in respect of young people's placement plans. There was an appropriate mix of information communication technology and manual recording. Staff had received training in relation to record keeping and data protection. Records were subject to regular review and oversight through the centre's quality assurance processes. Information was provided relating to each young person on their admission to the centre and this was regularly reviewed and evaluated. There was a robust focus on identifying goals and assessing outcomes.

Inspectors found that team and management meetings took place regularly and were well attended although there some deficits in how these were recorded. Improvements were required to facilitate the efficient and effective review of information, evidence robust governance and support decision making. The records of these meetings did not include an agenda, standing items and follow up of actions from previous meetings and this must be addressed by management.

An issue of risk was highlighted in the centre and it was identified that ligature knife training was required. Some staff had not received this training at the time of inspection however this information was not used to manage the roster and ensure that a person qualified to use the knife was on each shift in the centre. Review of the staff rotas found that on occasion a number of staff with no training were rostered together. Management must ensure that information relating to staff training informs day to day planning in the centre.

Inspectors found that there could be better evidence of evaluation of information relating to the staff team. It was clear from review of the records, questionnaires and inspection interviews that the staff team were struggling with some aspects of the work. This was reported to management in supervision and in team meetings. While some supports were provided to the team there was a lack evidence of an escalation process and a formal response to this issue from the management team.

While there was evidence that staffing shortages earlier in 2020 were brought to the attention of the board of management there was a lack of evidence of a root cause analysis and specific actions to address trends arising from review of staff exit interviews. Some actions had been taken to support staff retention however inspector found that the information available to management should be recorded, escalated and used more effectively to support the delivery of consistent quality care. The staff team had requested support from the organisation's contracted psychotherapist in September 2020 but this had not been facilitated by the time of this inspection in November. This centre has had significant difficulty with staff recruitment and retention and records showed that unless this issue is addressed promptly it is probable that more staff will leave. This high turnover of staff is not without impact on young people living in the centre. Management must review the staff retention issue to improve staffing continuity in the centre.

Records of incidents that took place were reviewed, analysed and used to inform planning documents and future practice. Inspectors found however, that some improvements were required in respect of recording the re-evaluation of identified risks. There was an appropriate risk register and safety planning process in place however it was not clear who was consulted when risk was being reviewed and safety plans being revised. In one situation it appeared that the centre had unilaterally re-assessed a situation of high risk and had not consulted with supervising social workers or specialist services involved in the case. The risk was then closed off although there was evidence to support that this was an on-going risk for this young person and should remain active.

One social worker confirmed that all information relating to their young person was recorded and communicated in a timely manner however a second social worker stated that they had had to request information which had not been provided. The registered provider must ensure there is appropriate sharing of all information to facilitate effective planning.

Each young person was provided with an information leaflet upon admission and this stated that they could read their daily log. This was not congruent with the organisation's policy relating to access to information which indicated that they could access all records created in the centre. Young people's parents were also provided with an information booklet at the outset of their placement. While this included reference to care and placement plans and regular updates it could be more specific in respect of how and why information is recorded and managed. The organisation's policy referenced parent's rights to access information but their information booklet

did not. The centre information booklets must provide more specific information as to how information is recorded and used. Inspectors found that every effort was made to update parents about information in young people's placement plans and progress reports.

There was some evidence that review of information informed service development through review of trends and patterns and through regular audits of the centre. Significant event review groups took place and learning was communicated to the staff team. One exit interview with a young person which had taken place since the last inspection was reviewed by inspectors. While there was no particular comments or points of learning relating to this feedback there was no evidence that feedback from young people was specifically reviewed by senior management.

Standard 8.2– Effective arrangements are in place for information governance and records management to deliver child centred, safe and effective care and support

Inspectors found that there was a detailed and comprehensive report writing and records keeping policy in the organisation's policy framework under theme 2 of the National Standards for Children's Residential Centres, 2018 (HIQA). This was dated June 2020 and due for review after one year. Further policies relating to the use of information, data protection and subject access requests were available under theme 8 of the National Standards.

There was evidence that in general that records were well written, up to date and subject to internal and external auditing processes. Inspectors highlighted one record which was not child friendly and raised concerns in terms of staff practice. The centre manager at the time had identified this issue and addressed the concern with the staff member in question. They were satisfied that this was a translation issue and was not meant as intended in the record. They stated that this had been addressed with the staff member involved and guidance and direction provided for future practice. There was no evidence on the young person's record that this was addressed by management and the record was not corrected. The proprietor must have a system in place to ensure the quality and accuracy of records at all times. Any inaccuracies on young people's files must include clarification through a robust quality assurance system and communication with the relevant social work department.

Inspectors noted that there were no consents from parents on young people's care files even though they were in a voluntary care arrangement. These must be sought from individual social work departments and filed on young people's care files.

There were policies and systems in place to outline who staff share and transfer relevant information with in a timely manner. While this was evident in practice in respect of one young person there were deficits in how information was shared and communicated for the second young person. The registered provider must conduct a review of how this young person's information is shared in the best interests of the young person and to facilitate the effective management of risk.

While there were policies and procedures relating to protecting the privacy of young people's information, inspectors were made aware of three instances whereby access to records was compromised and one of these included a data breach. These were all notified to relevant persons and the young person whose information was accessed by another was facilitated to make a complaint. This was processed and brought to conclusion. There was evidence that the data controller within the organisation reviewed each situation and that they communicated with the assistant data commissioner for guidance and direction. Appropriate remedial action was taken in the form of an action plan after each situation. There was not however, evidence that these issues were addressed sufficiently at management and team meetings or that they were specifically escalated to the board of management for their attention. Management must ensure that more robust preventative measures are implemented to protect against data breaches of sensitive information. These measures should be incorporated into practice and subject to review.

There was a policy in place for the retention and destruction of records. The policy dictates that the social work department for each young person receive young people's care files back when they leave the centre. While this has happened on occasion, other social work departments have refused to receive the records back. This has resulted in the records which were created for Tusla remaining the responsibility of the private provider. There was no policy for the escalation of issues such as this within Tusla and this is recommended. The organisation was in the process of developing an archiving system at the time of this inspection as it was not clear from review of registers where information relating to past young people was held.

There was a policy in place for managing requests and access to information. Inspectors found that there was confusion in respect of the policy about access to

information for young people. The policy stated that young people could have access to all records relating to their care on request (with three exceptions) whereby it would be explained to them why they might not be allowed to read some of their information. Some staff understood that young people could read their daily logs but that they could not read any other information such as significant events due to their age or because it could be traumatic. They did not reference that this would be based on an impact risk assessment as per organisational policy. Inspectors found that there were different interpretations of the access to information policy across the management and team. Also, social workers understood that young people would be facilitated to read their information if it was deemed appropriate. Inspectors were informed in interviews that requests to access the records would not be passed to the social work departments. The registered provider must ensure that policy procedure relating to access to information is fully understood and implemented in practice. The social worker for one young person had not been notified of the young person's request to access their information. This should be part of the services notification system.

Compliance with Regulation	
Regulation met	**Regulation 17**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 8.1** **Standard 8.2**
Practices did not meet the required standard	**None identified**

Actions required

- The registered provider must ensure that records of team and management meetings include an agenda, standing items and follow up of actions from previous meetings to facilitate the efficient and effective review of information, evidence robust governance and support decision making.
- The registered provider must ensure that information relating to staff training informs day to day planning in the centre.
- The registered provider must ensure that there are parental consents on young people's care files when they are in a voluntary care arrangement.

- The registered provider must ensure that there is evidence of evaluation of information relating to staffing, recruitment and retention and that remedial actions are implemented and reviewed for efficacy
- The registered provider must ensure that information available to management from exit interviews should be recorded, escalated within the organisation and reviewed to inform service improvements
- The registered provider must ensure that there is evidence of consultation with all relevant professional when risks are being re-evaluated, reviewed and revised.
- The registered provider must ensure that information booklets for young people and parents contain specific information as to how and why information is recorded and managed.
- The registered provider must ensure that there is evidence that feedback from young people informs service improvements.
- The registered provider must ensure that there is an escalation policy to senior management in Tusla for situations when they are not meeting their obligations in respect of records for children in care.
- The registered provider must ensure that more robust preventative measures are implemented to protect against data breaches of sensitive information. These measures should be incorporated into practice and subject to review.
- The registered provider must ensure that policy procedure relating to access to information is fully understood and implemented in practice.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
4	The registered provider must ensure that there is consultation with medical professionals if required, and that each young person's individual crisis management plan specifies if there is a contra indication to restraint or not.	There will be on-going consultation with medical professionals when required. This is recorded and documented in contact forms and stored in young people's contacts. Each young person's ICMP will highlight if there are any known contra-indications.	We will ensure that each young person's individual crisis management plan specifies if there is a contra indication to restraint or not. If there is a contra indication, ensure that the GP is contacted to obtain medical advice, and this is recorded and documented clearly on the ICMP. We will ensure that this process is completed and documented upon admission to whilst completing the general check-up.
8	The registered provider must ensure that records of team and management meetings include an agenda, standing items and follow up of actions from previous meetings to facilitate the efficient and effective review	The team meeting template in the centre has a set agenda, standing items and follow up recommendations to be reviewed. The manager's meeting template has been updated following inspection.	We will ensure that that the team meeting and manager's meeting template is followed effectively ensuring that minutes include an agenda, standing items and follow up of actions from previous meetings. This will support the efficient and effective review of information. We will also ensure that team

	of information, evidence robust governance and support decision making.		members are trained into the effective recording of team/manager meetings as part of the induction process and that information gathered in these forums are implemented effectively into day-to-day practice. This training will be recorded and documented in supervisions/ supplementary supervisions to evidence this process.
	The registered provider must ensure that information relating to staff training informs day to day planning in the centre.	The rota is now structured to ensure that staff training informs day to day practice (Example: ligature trained staff on duty each day). Staff training is reviewed monthly to ensure that all staff training needs are up to date. Recent training audit completed on the 1st of December. Any additional training required to meet the needs of the centre are outlined to senior managements and sourced effectively.	Centre managers and senior management to ensure that information relating to staff training informs the day to day planning in the centre. Oversight will take place through review of monthly training audits of centre and cross referencing it with the online rota system in place.

	The registered provider must ensure that there are parental consents on young people's care files when they are in a voluntary care arrangement.	Centre manager has followed up with the relevant social work department on the 10/12/2020 requesting follow up with parents to sign consents for young person in a voluntary care arrangement.	When completing consent forms for young people in voluntary care, we will ensure that this process is not only completed verbally and that the parents sign these consent forms directly along with the SW.
	The registered provider must ensure that there is evidence of evaluation of information relating to staffing, recruitment and retention and that remedial actions are implemented and reviewed for efficacy	Staffing issues or concerns within the centre are notified to senior management via the weekly governance report. Full staff team is recruited for the centre. Staff probations and appraisals are monitored and evaluated effectively to support staff retention and moral. Outstanding appraisal and probation to be reviewed before week ending 18th December.	Senior management will ensure effective oversight and governance in relation to staffing, recruitment, staff appraisals and probation reviews during spot inspections / themed audits and weekly governance reports issued by the centres. Centre management meeting and senior management meetings now include staff retention & additional supports required on the agenda
	The registered provider must ensure that information available to management from exit interviews should be recorded, escalated within the organisation and reviewed to inform service improvements	Remedial actions to support staff retention was discussed in the managers meeting on 03rd December, various approaches were explored. Exit interviews are always offered (when appropriate) to any employee leaving the	Senior management will ensure that a register is on file in each centre to record any exit interviews that have been completed /not completed to ensure full review, tracking and oversight. Exit interviews discussions have been added to the monthly managers meeting agenda

		organisation and are reviewed with centre manager and senior management. Staff personal files have now been updated to outline that they declined to engage in the process of completing an exit interview when encouraged to engage in this process.	which will be reviewed on a monthly basis and inform appropriate service improvements.
	The registered provider must ensure that there is evidence of consultation with all relevant professional when risks are being re-evaluated, reviewed and revised.	Following this inspection, the process of revising, reviewing and re-evaluation risks were updated. From 20/11/2020 it was ensured that risk assessments were effectively shared and there was consultation with the social work department and other relevant professional to ensure effective evaluation of risks. The consultation process is now attached to the risk assessment to ensure clear and transparent mapping of risks assessment processes.	A survey monkey is currently being developed for all employees across the organisations to gather information as to what service improvements could be implemented across the organisation. Senior Management will continue to have oversight of centres risk assessments to ensure that all relevant professionals relating to the YP are consulted in relation to risk assessments and safety management plans. Senior management will ensure oversight through review weekly governance reports, themed audits and spot inspections.
	The registered provider must ensure that information booklets for young people and	Young people's and parents' information booklets were updated following the inspection to ensure that it clearly outlines	Senior management will ensure all centres throughout the organisation will be issued with the updated young person's / parents

	parents contain specific information as to how and why information is recorded and managed.	how and why information is recorded and managed.	information booklet from December 2020. The young person's / parents information will be reviewed on a yearly basis by senior management.
	The registered provider must ensure that there is evidence that feedback from young people informs service improvements.	Feedback from young people is regularly sought during young people's meetings and at statutory child in care reviews. Any young person being discharged from the centre will also be offered a feedback form relating to their care in the centre and these are on file. Feedback from the young people's meetings are reviewed and discussed in the team meetings and noted in the weekly governance report which is sent to senior management. Any young people's exit interviews will be discussed at centre manager meeting minutes on a monthly basis.	Senior management and centre manager will ensure effective governance of young people's meeting and feedback forms on the child in care reviews forms. These, along with young people's exit interviews will be reviewed in team meetings and management meetings. All feedback is welcomed to inform service improvements across the organisation.
	The registered provider must ensure that there is an escalation policy to senior management in Tusla for	The senior management team are currently developing an escalation policy. This will outline the organisation's escalation process to senior management	The escalation policy will be reviewed at next centre managers meeting in January 2021 to inform the managers of the escalation procedures with Tusla. Senior

	situations when they are not meeting their obligations in respect of records for children in care.	in Tusla for situations where they are not meeting their obligations in respect of records for young people in care. The centre manager will ensure that the team read and sign the escalation policy once approved. We will ensure that this policy is discussed in team meetings and that all staff understand the policy.	Management will ensure the policy is adhered to from reviewing the weekly governance reports, spot inspections and themed audits.
	The registered provider must ensure that more robust preventative measures are implemented to protect against data breaches of sensitive information. These measures should be incorporated into practice and subject to review.	Risk assessments have been implemented within the centre to ensure more robust preventative measures have been implemented to protect against data breaches. Any data breaches / near misses will be escalated to senior management and relevant professionals. The team will receive re-training in GDPR in the new year.	The centre manager will ensure full implementation of all risk assessments relating to preventative measures to reduce the risks of any data breaches from occurring in the centre. Senior management will ensure the staff teams understanding of the data protection policy. The implementation of this policy in the centre will be reviewed during the next themed audit to ensure its full compliance.
	The registered provider must ensure that policy procedure relating to access to information is fully understood and implemented in practice.	The organisation's policy relating to access to information will be reviewed at the centre team meeting in December to ensure all staff members working in the centre fully understand the policy and that	Senior management will ensure that staff in all centres across the organisation fully understand the policy relating to access to information. This will be reviewed during themed audits and spot inspections. Senior

		it is fully implemented in practice.	management will speak with staff during audits to ensure they have a clear understanding of the policy and how it is implemented into practice.