An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: ID 183

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**10th & 11th March 2021**
Registration Status:	**Registered from 2nd December 2020 to 2nd December 2023**
Inspection Team:	**Lisa Tobin** **Eileen Woods**
Date Report Issued:	**23rd July 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 its first registration on the 2nd December 2020. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from the 2nd December 2020 to the 2nd December 2023.

The centre was registered to provide care for four young people of both genders from age ten to fourteen years on admission. The centres stated purpose was to provide high levels of support to young people on a medium to long term basis. The model of care was described as attachment and trauma based with the inclusion of psychology, art psychotherapy, education and an accredited experiential learning provision. It also included the recently implemented CARE framework (children and residential experiences, creating conditions for change).
There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 5th May 2021 and to the relevant social work departments on the 5th May 2021. 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 10th June 2021. 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 183: without attached conditions from the 2nd December 2020 to the 2nd December 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

Inspectors found that there was evidence of staff awareness of Children's First guidelines and relevant legislation which was seen through interviews and reviewing questionnaires. It was evident that the staff had undertaken relevant training associated with their role during the three-week induction. Policies and procedures were updated in March 2021 after being reviewed by the policy and procedure subcommittee group. The policies and procedures included all relevant policies around child protection and safeguarding in line with legislation.

Inspectors reviewed the Child Safeguarding Statement which included the associated risk assessment for the centre and appropriate responses to minimise those risks in line with the centres policies and procedures. The procedures identified that all staff were trained in first aid, safe talk and I Assist. Inspectors found that five staff were trained in first aid and none were trained in safe talk or I Assist. Inspectors were informed there were delays to training due to Covid 19. This training must be undertaken by the staff team given the current issues that had been identified in the centre. The role of the Designated Liaison Person and the role of mandated persons was also identified in this document. This document was reviewed in 2020 and will be reviewed every two years.

The centre had a register to record child protection concerns, there were no reports entered to date. There was a bullying policy in place and inspectors were informed by staff and management during interviews that bullying was not an issue in the centre. There were other policies in place that addressed behaviour management such as the policy on Supporting Behaviour Change, Management of Challenging Behaviour, Therapeutic Crisis Interventions and Guidance on Restrictive Practices. However, it was noted by inspectors through file review of daily logs, significant events and case reviews that despite the policies and procedures in place, the current placement for one young person was not appropriate and this was verbalised by management and the team that they were not meeting the young person's needs as defined in their own model of care.

The policy on Children's Rights was reviewed by the inspectors linked with the UN Convention Rights of the Child which addressed that children have a right to feel safe. One young person in the centre repeated feeling unsafe due to the actions of a peer. These concerns were documented in young people meeting minutes, daily logs and in key working sessions. Despite the young person declining a complaints form, management or staff did not advocate for the young person on this matter and escalate the issue as a complaint. Management must address the impact on others when reviewing significant events and the potential effects as discussed in the policy on supporting behaviour change.

All staff completed Children's First online eLearning training. The majority of the team had completed further external training with Barnardos regarding Children's First and the organisations Child Protection policies. Inspectors found that staff had a good awareness of child protection procedures and safeguarding policies, however this was not robust enough due to the difficulties the staff team faced in managing the behaviours presented. During interviews, staff were able to give accurate information around their role as a mandated or non-mandated person and details of the responsibilities attached to reporting a concern. An allocated social worker spoke of an emphasis on child protection in the centre, in particular the safeguarding of young people. Staff received the required training around child protection and safeguarding at induction and through the organisations training and awareness programme.

Staff in the centre work in partnership with families, social workers and guardians and this was documented in significant event notifications and in handover reports. Social workers were sent up to date risk assessments, monthly reports and safety plans identifying ways they were promoting the safety and wellbeing of the young people.

There was evidence of strategies in place to support the young people around self-care and protection. Inspectors reviewed safety plans, daily risk assessments, individual crisis support plans and key working reports that identified areas of risk and how to ensure the risk is minimised. Inspectors noted that young people's vulnerabilities had been identified across numerous risk documents. However, despite the plans in place, these were not being realised due to the incorrect placement of a young person.

There was a policy and procedure on protected disclosures in place in which staff showed great knowledge of its content during interviews and in questionnaires. Staff

also expressed confidence in using the policy should the need arise. To date, there were no protective disclosures made.

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

The organisation had a policy on the management of challenging behaviour in place. Staff were trained in a recognised model of behaviour management at induction and received refresher training when required. The staff showed an awareness of the underlying causes of behaviour from the young people and how to appropriately respond to these with guiding documents and training. The organisation used shared knowledge about the young people when applicable. The team had risk assessments and individual crisis support plans in place to respond appropriately to challenging behaviours. Inspectors noted some of the individual crisis support plans were unsigned. These documents were reviewed regularly by staff and management at team meetings and after incidents with input from the clinical team. There were occasions where some behaviours were deemed proactive and staff identified these as an ongoing concern due to the unpredictability of the behaviours presented. Management sought guidance from CAMHS and the clinical team about how best to manage these situations with safety being the priority. Medication reviews were also in place linked with CAMHS, in order to address dysregulation of a young person.

Staff used their relationship and positive reinforcement to help deescalate challenging behaviours. The centre used an attachment and trauma informed model of care which helped to guide the staff in dealing with the complex behaviours presented by the young people. Staff were able to identify specific high risks behaviours of the young people and used their knowledge and key working opportunities to address these risks and implement alternative behaviours. These included absent management plans and the use of sensory activities. The staff showed awareness of the young people's mental health and identified that past incidents may have impacted their current behaviours. During interviews and reviewing questionnaires, staff highlighted the concerns they had over the behaviour of one young person and the ability to manage this safely. When reviewing the significant events register, the number of assaults on staff and the impact the behaviours were having on the other young person, it appeared that this situation was not managed safely.

Inspectors reviewed the training analysis report which showed the induction process included all relevant mandatory training. There were other training needs identified

by the team based on the current needs of the young people that were outstanding namely information about ASD, safe talk and the safe administration of medication. Due to Covid-19, these training pieces have yet to commence. Literature was given to staff from the clinical team in the interim to help guide their work practices.

There were many ways in which inspectors were able to review the auditing and monitoring mechanisms of managing behaviours that challenges. Incidents were discussed at team meetings and during supervisions. There was a significant event review group (SERG), which included members of the clinical team, organisational senior social workers and a therapeutic crisis intervention trainer. Case reviews and strategy meetings were also undertaken by multidisciplinary teams and the social work department. The quality, content, structure and outcomes of SERG needs to be reviewed as the outcome process was not effective. The SERG identified that the placement was not suitable however, the young person remained resident in the centre. A review of the SERG needs to occur to ensure all outcomes are addressed and followed through in a timely manner for the benefit of the centre and the young people.

There was oversight of potential harm to the young people from each other through the group impact risk assessments, safety plans and daily risk assessments. Inspectors noted there was a high level of self-harm from one young person who also displayed serious levels of aggression and physical assault towards the staff. These regular aggressive outbursts and level of violence was rated high risk in the centre. Punching staff, hair pulling, biting staff, kicking staff and isolating staff in order to assault were some of the presenting behaviours. Staff were trained appropriately, had supports from the clinical team and implemented the plans in place but the level of intensity continued during the young person's placement. The level of aggressive and challenging behaviour required a review of staffing which was increased to three sleepover staff for a month. The increase in staffing did cause a decrease in the aggressive behaviours for that period. A positive covid test for the young person also occurred at the time of decreased aggression. It was unclear if the extra staffing or positive test caused the reduction in aggressive behaviours. Both senior management and centre manger informed inspectors that the current placement of this young person was no longer viable and notice of discharge had been given to the social work department. Through many strategy meetings, significant event reviews and case reviews, it became clear to the organisation that the model of care was not applicable to this young person who required a more intensive supported setting.

Inspectors reviewed staff files which showed that debriefs occurred after incidents and staff were supported by management and by the clinical team when it was required. Some new staff were receiving supervision every two weeks in line with the supervision policy due to being a new staff member.

There was a restrictive practice policy in place. The centre had a restrictive practice log which included details of environmental and physical restraints. All were documented in the log and some were unsigned. These were reviewed every three months by the team and extended if required. There was no review of how effective the restrictions were. Centre management and the team must review effectiveness of the restrictions when reviewing the log. The majority of environmental restrictions such as locked presses, access to cutlery and crockery were due to the self-harm of one young person. These restrictions impacted the other resident in the house and impacted the homely feel. The young person voiced annoyance of the environmental restrictions repeatedly but refused a complaints form when offered by the staff. The staff did not progress a complaint on behalf of the young person on this matter either. The centre manager and team need to ensure the impact on the other residents are considered when putting restrictive practices in place and act on their behalf as advocates if they repeatedly make the same complaint.

There was another environmental restriction of alarms on bedroom doors. This was removed from one young person's bedroom after agreement from the team due to a request by the young person. This alarm had to be reinstated after the young person absconded during the night which the staff team were not aware of until the following morning. The young person's risk assessment had identified absconding as a high risk and this should have been the guiding practice for keeping the alarms on the bedroom doors at all times. The young person absconded, came to the attention of the local authority which resulted in a month's detention in the juvenile justice system. The centre manager must follow the risk assessments in place and ensure the young person's safety is priority. Procedures need to be in place to ensure staff can become aware of any young person leaving the building at night time.

Physical restraints were used for one young person as guided by the individual crisis support plan to deescalate challenging and abusive behaviour. The majority of physical restraints carried out were in compliance with policy and procedures applicable to the young person's care plan and safety plan. However, when reviewing the significant event notifications, inspectors noted that incidents occurred where a number of physical restraints were being carried out daily. Inspectors noted during one incident when a young person was in hospital, there were seven individuals from

the hospital restraining the young person in order to give a sedative. This was only a week after admission to the centre and a professional's strategy meeting was called due to the concerns of the appropriateness of the placement and ability of meeting the young person's needs. The outcome of the meeting included an increase of medication and the availability of PRN medication, robust daily plan and the ongoing strategies identified at the recent child in care review. Despite these actions, high numbers of incidents continued to occur.

Inspectors noted one incident where a non-routine restraint was carried out. A SERG was carried out and a review of physical interventions occurred. Sourcing inpatient treatment was one of the identified outcomes. Inspectors reviewed the significant event form which included a place for details about any non- routine restraint. Inspectors also noted that non-routine restraints are not mentioned in any policy relating to behaviour management. Only approved and agreed techniques of restraint must to be used.

It was noted that PRN medication was used alongside restrictive practices however, it was noted that staff had not undertaken relevant safe administration of medication training. Staff and members from the SERG team raised concerns around the practice of carrying out physical restraints and the level of medication prescribed for one young person. TCI guidelines refer to guiding factors in when a physical restraint should and should not be implemented, naming medication as one of the deciding factors. Inspectors noted that a consultant psychiatrist from CAMHS was involved and deemed the practice of physical restraint safe. Staff must complete safe administration of medication training which should be a priority given the staff concerns highlighted above.

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

The organisation had a policy on significant events which included policies on risk assessment and risk management/reduction and a policy on unauthorised absences. During interviews the centre manager and staff spoke about supports available for the team through supervision, team meetings, debriefs and ongoing training. Staff were aware of the whistleblowing policy and how to raise concerns if needed. The young people participated in young people meetings where they were given the opportunity to give feedback on their care or other aspects of their life. The young people were given the opportunity to participate at their reviews or to complete a written report if not attending in person to ensure that their voice was heard. The staff spoke to the young people about EPIC and VOYPIC. The complaints procedure

was outlined in the young person's booklet and discussed at the young people's meetings.

There were mechanisms in place for parents, social workers and guardians to have involvement in the young people's lives. Inspectors noted that family and social workers were informed of incidents when they occurred. Family were given updates by the team and were invited to reviews and relevant meetings. The social worker stated that they would provide feedback to the team at professional and strategy meetings and when incidents would occur. Monthly reports, placement plans, safety plans and absent management plans were sent to social workers which informed them of changes or areas for improvement.

Significant events were reviewed at team meetings, during supervisions and debriefs. If a trend in behaviours was identified, a SERG meeting would occur between management and members of the clinical team. Inspectors reviewed SERG reports where staff were given feedback about actions and showed how the incidents were evaluated. Inspectors also noted that if there were ongoing high risk concerns, a case review would be called to identify what changes, support or training are required. There was evidence from management meetings and governance meetings where incidents were discussed and red flagged due to ongoing concern/risk and actions identified to support the team and young person. Even though there was a system in place to review incidents, these reviews were not effective in bringing about change in the behaviours of the young person. The outcome from these reviews showed that the centre cannot safely manage the young person and the young person will only remain there until a new placement is sourced.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The centre manager must ensure the staff team are trained in first aid, safe talk and I Assist as identified in the Child Safeguarding Statement.

- The centre manager must review the SERG to ensure all outcomes are addressed and followed through in a timely manner for the benefit of the centre and the young people.
- The centre manager must continuously review the impact risk assessments and consider the impact incidents have on other young people.
- The centre manager and staff must review effectiveness of the relevant restriction practices and the impact on all the young people when reviewing the restrictive practices log every three months.
- The centre manager must follow the risk assessments in place and must prioritise the young person's safety. The centre manager must ensure there are procedures in place to ensure staff are aware of any young people leaving the centre at night time.
- The registered provider must ensure that only approved and agreed techniques of restraint are used.
- The centre manager must ensure the team receive all relevant training to support them in their work with the young people in particular the safe administration of medication.

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

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The registered proprietor through their director of care and quality, regional management team and therapeutic team had a structure in place dedicated to ensuring good service delivery for children and young people which was in compliance with the requirements of relevant legislation, regulations and National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence from the centre manager and staff team of their awareness of regulations and standards from their interviews and questionnaires. There was a link across the organisation of support services available from the clinical team and from senior management. Despite the organisational and centre supports available, deficits were found in the practices in the centre.

Inspectors identified issues regarding the organisational care practices and operational policies around the movement of placements of young people within the organisation itself. The movement of the young person had been noted by inspectors within the organisation and the concern related to the suitability of these moves and the pace at which they occurred. The organisational policy on admissions stated that admissions were planned, however two young people were admitted to the centre over a four-day period which was against the organisations policy. One young person's transition plan to this centre was approved with the intention of a single placement for the first 4-6 weeks. Oversight from the registered proprietor must occur regarding the movement of young people, the impact on the young person, the impact on the new centre and the other young people in that new centre.

Inspectors reviewed internal audits that were part completed relating to theme 3 and fully completed for theme 4 against the national standards. There were also action reports reviewed which guided the centre in what was required to become fully compliant with that relevant theme. As the centre was opened 4 months previous, there were no other audits available to the inspectors against the standards. Inspectors reviewed an internal house file review of the documentation used which

was very detailed and identified actions required. Inspectors looked at other minutes from manager meetings and governance meetings which showed good oversight of the centres.

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.

The current manager and deputy manager were qualified and had the relevant experience for their respective roles. Staff highlighted through their questionnaires and interviews that despite the challenging behaviour they were dealing with, the support received from management had been continuous and of great value. Social work and guardian ad litem feedback also reported a positive experience of interaction with management and the team. It was reported to inspectors that the leadership was of a high standard and that the young people's needs though challenging, were being met in so far as possible given the circumstances. The centre manager and deputy manager showed their leadership abilities through the provision of supervision, holding team meetings, providing debriefs promptly, oversight of documentation and while providing support when on shift.

There was evidence of the oversight of all personnel from director level to social care worker across the centre records and across the manager's weekly operational records to the senior management. There was knowledge of the internal and external management posts that exist within the organisation. There were job descriptions in place for all staff. There were clearly defined governance arrangements and structures which outlined the authority and accountability for the centre.

The registered proprietor had a contract in place with the funding body Tusla, The Child and Family Agency. The company did have an agreement with a health authority in Northern Ireland to facilitate the placement of a young person.

The current person in charge was the centre manager and inspectors found that there was a clear understanding of the role and responsibilities which was evident in their daily work.

Inspectors reviewed the organisations policies and procedures that were updated in March 2021. There was a policy review group initiated within the organisation which the regional manager was part of. Inspectors were informed that policies were

updated as required or when a change occurs in a policy. However, there was no review date or version number on the policies and procedures document to evidence when the next formal review will take place. Policies were discussed during team meetings and policy development was discussed at both senior manager meetings and at governance meetings.

There was a risk management framework and set of procedures in place. There were supporting documents such as risk management plans and individual crisis support plans. The individual development plans, group impact risk assessment and the absence management plans were regularly reviewed in collaboration with the multidisciplinary therapeutic team. Inspectors were informed that pre-admission risk assessments were in place for the young people at the centre but the inspectors were not furnished with these and they were not available in the records to review. Without seeing the pre-admission risk assessment, the inspectors were unable to see how placement planning occurred prior to the admission. The staff on duty undertook daily risk assessments when required. The organisational risk register was in place and the centre risk registers have been introduced as an outcome of previous inspections.

The deputy manager currently acted up when the manager was not present in the unit. There was evidence this occurred in the centre through reviewing associated documents when the deputy stood in for the manager. Leadership was shown by the deputy as reflected in the oversight of paperwork, attendance at professional meetings, a strong working relationship and understanding of the needs of the young people. The delegation of tasks was noted in supervision records and on the manager's handover checklist.

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The statement of purpose and function identified this centre as providing a service for up to four children and young people aged 10-14 on admission. The statement listed the management and staffing numbers for the centre. There was no review date attached to this document. The organisation updated the purpose and function in November 2020 as the model of care was updated at this time. It clearly described the model of service delivered by the company through its central hub. Some of the services provided included psychology, art psychotherapy, education and occupational therapy. The centre had introduced the CARE model to the service which was mentioned in the updated statement of purpose and function. This should

be expanded on to provide more information on the CARE model as the team focus on its principals and were all trained in it. The aims, objectives and range of multidisciplinary therapeutic, educational, outdoor and clinical services it offered were well described.

Through interview and questionnaires staff showed knowledge of the CARE model and were able to identify the different pillars that were applicable to the young people. Staff stated they had been trained on the model of care and in the CARE framework during the induction period. The statement of purpose and function was available to staff in the office. Social workers were aware of the statement of purpose and function. The young person's booklet and family booklet identified the information relevant to the statement of purpose and function.

No audit had been carried out against the national standards as outlined in Theme 5, as the centre was only in operation since December 2020.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

There were internal audits against the National Standards for Children's Residential Centres 2018 (HIQA) undertaken each month. As this centre was in its infancy, there were only two audits available to the inspectors. There was a quality assurance compliance officer in place whose role as an external auditor to the team, can help identify areas of improvement for the team and ensure the centre is compliant with governance arrangements. Reviews of practice occurred during team meetings, senior management meetings and governance meetings which would bring about changes relevant to the centre and the whole organisation. Actions identified from these meetings were followed through by relevant people and given a timeframe for completion. Staff received relevant training during induction and further training was provided by the organisation through the training awareness development programme. Further training was arranged for the team that was specific to the needs of the young people but had been postponed due to Covid 19.

The continuity of care was evident to the inspectors by the centre manager, deputy manager and the team. The quality of the reports and oversight of risk was seen by the inspectors through an abundance of risk associated documents. The safety of the young people in the centre was at times compromised by their own challenging behaviours or being exposed to their peers behaviours. Staff attempted to address

these risks as promptly as possible to minimise the level of risk to the young people and to staff through guiding documents and relevant interventions. Guiding documents such as risk assessments, individual development plans and individual crisis support plans were reviewed regularly by management, the team and external personnel.

Governance management meetings were held monthly with the director of care and quality, director of human resources and a clinical team lead. Their meetings included discussions about risk associated with operations, clinical, training, health and safety, administration, and GDPR. The updating of risk registers and any "red flags" within the organisation was also discussed. The minutes were detailed and the discussions covered a multitude of governance tasks and assigned actions to relevant people.

Inspectors reviewed the complaints register and the child protection welfare report register and both had no records entered to date. Inspectors noted when reviewing the complaints register that staff had not entered in the complaint repeated by a young person of feeling unsafe and inspectors had not noted any follow up work carried out with this young person around addressing these feelings. Significant events were reviewed by inspectors and were recorded in the register as required. Inspectors also saw evidence of case reviews which were carried out when addressing serious concerning behaviours. Inspectors reviewed feedback forms from the SERG that were given to the team in order to guide and promote improvements. The role of the significant event review group was to monitor and analyse the behaviours of the young people and the responses from staff in order to learn from these incidents and to provide insight to the team. Incidents were also reviewed at team meetings and during supervision. It was evident that the team attempted many interventions in order to promote positive change with the young people however, the most recent case review highlighted that this centre was no longer a suitable placement for one young person, which was also having an impact on the other young person living there.

An annual review of compliance for the organisation was not seen by the inspectors. A reporting document was currently being drafted that will capture each centres compliance and the improvements required.

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

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

Actions required

- The registered proprietor must have oversight regarding the movement of young people, the impact on the young person, the impact on the new centre and the impact on the other young people in that new centre.
- The centre manager must review the process for complaints.
- The registered proprietor must provide more information about the CARE model in the statement of purpose and function.
- The registered proprietor must ensure that an annual review of compliance is in place as outlined in the National Standards for Children's Residential Centres 2018 (HIQA).

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure the staff team are trained in first aid, safe talk and I Assist as identified in the Child Safeguarding Statement.	With immediate action. The centre manager has linked with the training team to advise of deficits in training.	We have now employed a second training officer to join the training team. The training team now meet with the Director of Care & Quality on a monthly basis to review any deficits/issues in obtaining training. This information is also presented to the governance committee on a monthly basis.
	The centre manager must review the SERG to ensure all outcomes are addressed and followed through in a timely manner for the benefit of the centre and the young people.	With immediate action	We have reviewed or SERG process and updated the policy on same to include a flowchart which outlines the process for completion. The SEN team will continue to liaise with Home Management in respect of completion of SERG's in a timely manner
	The centre manager must continuously review the impact risk assessments and	With immediate effect and to continue on a regular basis	We have reviewed the template for our GIRA to reflect continuous updating on a

	consider the impact incidents have on other young people.		regular basis of young people living in the home and not just at the time of admission. Any concerns presented during the updating of a GIRA in terms of high risk, which we have concern with managing will be informed to the relevant Regional Manager.
	The centre manager and staff must review effectiveness of the relevant restrictions practices and the impact on all young people when reviewing the restrictive practices log every three months.	With immediate effect. This will be reviewed via monthly team meetings	All restrictive practices which remain on a restrictive log for a longer period of time than first though will be informed to the governance committee for review. We also intend to have audits completed by our compliance officer for an independent overview on processes. Regional managers will also review the restrictive log as part of their monthly visits to the home.
	The centre manager must follow the risk assessments in place and must prioritise the young person's safety. The centre manager must ensure there are procedures in place to ensure staff are	With immediate effect. Home Management reviewed this situation with the team and clear risk assessments and expectations were discussed	As with any new team, continuous teaching and coaching, regular supervision with staff, clear expectations and risk assessments discussed on a daily basis.

	aware of any young person leaving the centre at night time. The registered provider must ensure that only approved and agreed techniques of restraint are used. The centre manager must ensure the team receive all relevant training to support them in their work with the young people in particular the safe administration of medication.	 With immediate effect. With immediate effect. Centre management have linked with the training team regarding same.	 We have initiated training for June 2021 in which we will have a TCI trainer allocated to each individual staff team. This will ensure on site governance in respect of ICSP's We continue to have regular training in relation to medication training. Covid has had an impact on our delivery of training, so we have been playing catch up in ensuring all staff are trained. The training team will co-ordinate this process and ensure that all staff are up to date with this training.
5	The registered proprietor must have oversight regarding the movement of young people, the impact on the young person, the impact on the new centre and the impact on the other young people in that new centre. The centre manager must review the process for complaints.	With immediate effect With immediate effect	Senior management have conducted a review of these moves and have looked at the learning for same, which will be brought to the governance committee for further discussion Regional management will oversee complaints for this home and will discuss

			same in supervision with home Management.
	The registered proprietor must provide more information about the CARE model in the statement of purpose and function.	With immediate effect. The SOP&F was updated in May 2021 across all homes and reflects the CARE model. This has been furnished to management and staff	Any changes/updates required will be discussed at the governance committee and updates will be conducted by the policy subcommittee team
	The registered proprietor must ensure that an annual review of compliance is in place as outlined in the National Standards for Children's Residential Centres 2018 (HIQA).	This will be in place further in the year as the home becomes established.	Our compliance officer will ensure that an annual review of compliance is in place for this home. The compliance officer has recently conducted a presentation to management teams on same