An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 014

Year: 2019

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Registration and Inspection Report

Inspection Year:	**2019**
Name of Organisation:	**Focus Ireland**
Registered Capacity:	**Four young people under 18**
Dates of Inspection:	**31st October and 01st November 2019**
Registration Status:	**Registered with attached conditions 13th March 2019 to 13th March 2022**
Inspection Team:	**Eileen Woods**
Date Report Issued:	**13th of January 2020**

Contents

1. Foreword **4**

1.1 Centre Description
1.2 Methodology
1.3 Organisational Structure

2. Findings with regard to Registration Matters **9**

3. Analysis of Findings **10**

3.2 Management and Staffing
3.5 Planning for Children and Young People
3.7 Safeguarding and Child Protection
3.10 Premises and Safety

4. Action Plan **21**

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in January 2003. At the time of this inspection the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions from 13th of March 2019 to the 13th of March 2022.

The centre was registered with a purpose and function that stated it would accommodate up to nine young people aged between 16 and 21 years of age that had substance misuse issues. The age range could rise to age 23 if no under 18's were accessing the centre. However, in 2018 Tusla the Child and Family Agency as the funding agency had requested a change in operations and the centre had ring-fenced beds for four young people aged sixteen to eighteen in need of emergency care on behalf of the Crisis Intervention Service/CIS. The stated length of stay in the purpose and function was a maximum of three days and the beds were for hard to reach young people in crisis. The young people must leave the centre at 9.30 am and cannot re-access the centre again until 6.30pm with some small variations on times. Day supports were the responsibility of the referring social work areas for the young people. There were three young people accessing the centre when the inspector visited, a fourth had recently moved and two young people left for different placements over the time of the inspection.

The inspector examined the relevant regulations and progress made as applicable to the corrective and preventive actions (CAPA) plan submitted in early 2019 in

response to the 2018 inspection report. Aspects of the national standards 2001 on Management and staffing, Planning for children and young people, safeguarding and child protection and Premises and safety were examined. This inspection was announced and took place on the 31st of October and the 01st of November 2019. A further meeting took place with the Director of Services and the service manager Focus Ireland and the inspectorate on the 28th of November 2019.

1.2 Methodology

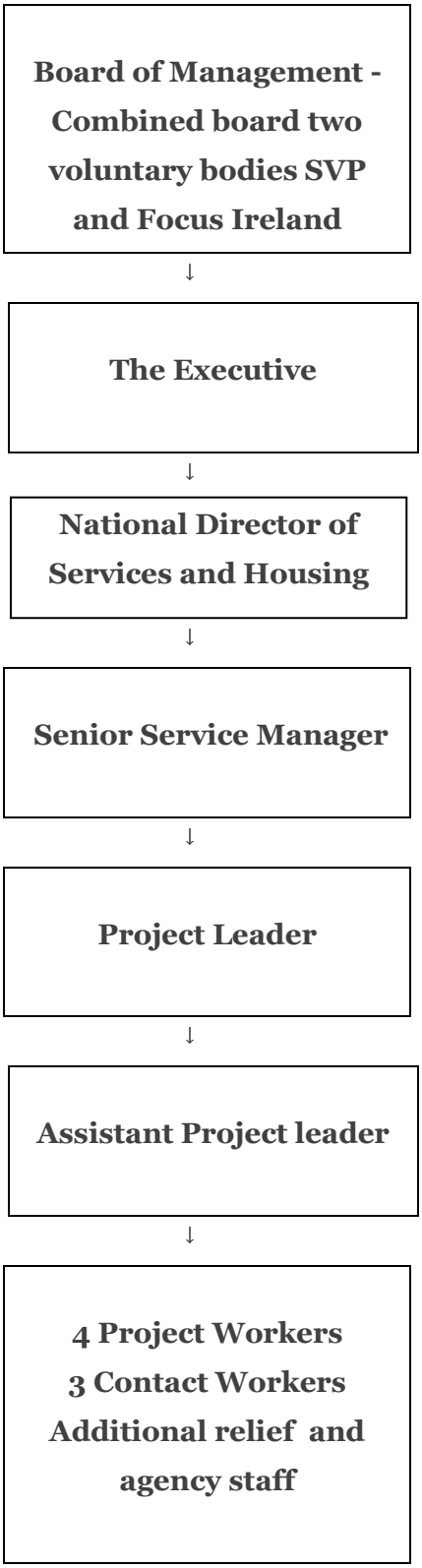
This report is based on a range of inspection techniques including:

- An examination of related documentation supplied by the project leader and assistant project leader
- An examination of the centre's files and recording process.
  - Care files
  - Supervision records
  - Handover book
  - Daily/nightly records
  - Minutes of team meetings
  - Minutes of board meetings for this centre
  - Minutes of board reports
  - Minutes of one project leaders/service manager forum
  - Risk register
  - Registers of significant events and the centre register
  - Personnel files x two
- Interviews with relevant persons that were deemed by the inspection team to have a bona fide interest in the operation of the centre including but not exclusively:
  a) The project leader
  b) The assistant project leader
  c) Two of the young people
  d) The Tusla Child and Family Agency PSW for the Out of Hours social work and CIS service
- Some observations of care practice routines and the staff/young person's interactions.

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.

1.3 Organisational Structure



2. Findings with regard to registration matters

A draft inspection report was issued to the project manager, the services manager, director of services and the relevant social work departments on the 6th of December 2019. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 20th of December 2019 and the inspection service will receive 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 not 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: 014 with attached conditions from the 13th of March 2019 to the 13th of March 2022 pursuant to Part VIII, 1991 Child Care Act.

The following condition was attached to the centre's registration under Part VIII, Article 61, (5) (b) (I) (II) of the Child Care Act 1991, at that time. The conditions being that:

1. That the corrective and preventative action plan (CAPA) is implemented in full.

The period of registration being from the 13th of March 2019 to the 13th of March 2022.

3. Analysis of Findings

3.2 Management and Staffing

Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

3.2.1 Practices that met the required standard in full

Register

A new centre register was introduced in January 2019. The register required on-going management to ensure it is accurate and up to date.

There was a system in place where duplicated records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

The action plan response related to register has been achieved.

3.2.2 Practices that met the required standard in some respect only

Notification of Significant Events

The standard and speed of reporting of significant events, SENs, had improved since the last inspection. The management had taken action to improve identification of events that should be notified and they reviewed significant events before they were sent to the relevant parties. The inspector found that there remained areas of improvement required for consistency in reporting and in detail regarding what is being reported. The threshold for holding risk was high but the team must remain vigilant regarding what is significant for these vulnerable young people. Reporting and recording should be part of the team meetings, supervision, training and auditing systems and this was not the case as yet. The service manager and the project leader did track numbers of SENs and frequency as well as recurring themes, for examples increases in drug related incidents. There was evidence that they then took action to act on those issues through local resources. There was a register of significant events in place and the management attended a crisis intervention service group significant event review meeting throughout the year. The action plan response to the notification of significant events had been partially achieved.

Referring and allocated social workers must give specific written guidance to the centre regarding the individual needs and risks for the young people.

Administrative files

The administrative files and young people's files did not evidence oversight; this may be due in part to the digital nature of many of the records. It could not be established where staff received feedback and direction on their work but there was evidence to support that this does take place, for example, action had been taken regarding staff practices were identified as required. The young people's files displayed improvements in layout and in the records of key working. Aside from their work and the management's actions to improve risk assessment and risk management tools the files did not effectively reflect the outline story of the young people from admissions, escalations and meetings if the placement extended and discharge. Some of the templates in use were outdated and not fit for the purpose of the placements.

The files did not contain core documents even where a young person stayed at the centre for a number of months or turned eighteen. The inspector did not see evidence that the social workers took action to independently visit the centre and read the file to satisfy themselves that the young person had the documents they would need, for example birth certificates, medical cards, PPS numbers and so forth. The action plan response to administrative files had been partially achieved.

3.2.3 Practices that did not meet the required standard

Management

The service manager committed to a monthly auditing process informed by an evidence based review of documents at the centre. They had completed two audits for this centre, one in April and one in June 2019. The format utilised was not specific to the type of service on offer and is a brief proforma document without a specific process regarding follow up. The audit findings did not feature in the meeting minutes at the various levels reviewed by the inspector. The audits would benefit from development, expansion and from the addition of outcomes and follow up sections. Presently the audit system on its own does not support a robust governance and oversight system. The service manager had identified items for follow up from the inspection report and in line with their own service reports, for example regarding staffing deficits and supervision. The service manager and the centre's project leader and assistant project leader were an experienced and qualified group who communicated daily regarding the centre. All were well informed regarding the placements and the intended purpose and function of the centre.

The governance structures for the centre had not been formally revised since the last inspection. The project leader and assistant project leader run this night service and

a number of day youth services. The assistant project leader looks after the day to day running of the centre inclusive of supervision, team meetings, handovers, admissions and discharges. They were overseen by the project leader who was present in the centre in the morning; they were copied on all communications and were available by phone or email. The project leader stated that they have consistently highlighted to line management the deficits in staffing and project risks but stated that they could stand over that there was high quality night time care for young people. They also stated that the team approaches were "deliberate and planned" through verbal discussion.

The centre had a risk register that included the governance, compliance and operational risks of the voluntary body and some for this centre within the voluntary body. The copy provided to the inspector had been created in 2017 and did not contain the updates on actions relevant to the governance, oversight and operational risks of this centre. January and May 2019 minutes of the board of management for the centre contained evidence that the specific risks were reviewed and the residual risks amended following discussion. The mitigating factors and actions were not explicitly outlined in the minutes but the board were aware of risks regarding staffing levels, types of placements and the roll out of new child protection procedures. An action from the board meeting was for the risk register to be updated with comments from the meeting. The service manager and the project leader attended both the board meetings. The board reviewed all aspects of the service inclusive of the four dedicated beds for the under eighteens, the five beds adult beds and a day service for vulnerable young adults some of whom had been care leavers.
The board were updated by a service update report presented by the service manager and this highlighted the challenges in the care of the complex needs of the under eighteens accessing the centre, the impact on staff, the lack of staff and the impact on the over eighteens accessing the project. The service manager report noted that the Child and Family Agency Crisis Intervention Service and Out Of Hours social work service management and the management of the centre were happy with the progress made in referral protocols and that a structure had been put in place where none existed previously (August 2019). A review had been held with the management of the Child and Family Agency Crisis Intervention Service to discuss interagency work and referral protocols. This remains an area requiring on-going action as differences in views regarding mix of young people and placements processes were an issue at the time of this inspection visit.
The centre committed to introducing a form of support planning for young people this has not been developed.

The action plan responses related to management and governance had not been achieved.

Staffing

The historical staff allocation for this centre was reported to be seven staff, an assistant project leader and a project leader. There had been vacant posts on the team and changes in management since 2017. There were three fulltime vacancies on the team. These posts had been altered to a different grade on a lower pay scale during the recession and the service manager has made a business case for the posts to be restored to a project worker, equivalent to social care worker post. The service manager report noted the three vacancies and described the lack of a full staff team as "on-going risk to young people and the existing staff team". The service manager named that no progress had been made in appointing a stable full time staff team for the centre. Inspectors also note that a higher allocation of staffing numbers would be required to ensure that training, team meetings, key working and general development of care within the centre take place. The organisation must urgently act to implement strategies to address the staffing issues within this centre. The inspector did not see evidence of actions from Director level of the organisation regarding this matter. The actions of the service manager, project leader and assistant project leader have ensured that the centre had remained open on a nightly basis.

The inspector found that on the logs there were twelve familiar staff names recurring between the four full time staff, relief staff and agency staff. There was frequently a core staff member on duty and the rosters took account of seeking to balance staff familiar to the young people and suitable to the centre. Three staff came on duty at 6pm, one finished at 3am, one at 8am and the third at 10am. This represented three staff with a possible maximum of nine young people and young adults overnight. The inspector found that the assistant project leader often had to work shifts and arrived before 7.30 am to facilitate a handover, a debrief and to be the second staff in the morning. The assistant project leader and the project leader also managed the operation of the day young adult case management team from the property. It was reported to the inspector that new premises was being sourced for the day service.

The inspector reviewed a sample of three personnel files and found that they did not meet the guidelines as set down by the Dept of Health circular 1994. This feedback had been provided to the organisation involved on previous occasions. The management of the centre had not reviewed the personnel files, as committed to in the action plan, in order to satisfy themselves as to the quality of the files.

The action plan response to staffing had not been achieved.

Supervision and support

The management had not made progress with conducting supervision in line with the policy guidelines. The assistant project leader and the project leader were trained in the organisations chosen model of supervision: clinical supervision. The assistant project leader identified that the impact of the organisation's implementation of the European Working Time Directive (EWTD) had resulted in less available hours for supervision and also had an impact on availability for team meetings particularly when training was taking place. They reported that due to the night time nature of the work that for every eight hours of training for example an eighteen hour rest period must be allowed. There were a small number of sessions recorded and therefore little for the inspector to review. There was a group reflective practice with a facilitator available for staff but the management described a low attendance at this also. The matter of team development and support through regular and reliable supervision and support must be addressed.

The inspector found that the team meetings book for 2019 contained evidence of seven meetings in ten months with the most recent being in August. Attendance numbers could be as low as three and generally there were an average of five people present with the records noting that the project leader and the service manager attended in April. It was clear from the minutes that developments were taking place or being attempted in line with the action plan from the last inspection but the impact of the lack of a full team and the effects of running multiples services was disrupting development taking place. The records maintained did not give information on all areas discussed.

The action plan response to supervision and support had not been achieved.

3.2.4 Regulation Based Requirements

The Child and Family Agency have met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV, Article 21, Register.***

The centre has not met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 5, Care Practices and Operational Policies
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***

-Part III, Article 6, Paragraph 2, Change of Person in Charge
-Part III, Article 16, Notification of Significant Events.

Required Action

- The organisation must urgently act to create a renewed strategic plan and responses to the regulatory compliance issues in care and operational practices and staffing.
- The organisation must provide the centre with a set of policies, procedures and working tools that support the purpose and function of the centre and are reflective of the National Standards for Children's Residential Centres (HIQA 2018), relevant regulations and legislation.

3.5 Planning for Children and Young People

Standard
There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

3.5.1 Practices that met the required standard in full
None identified

3.5.2 Practices that met the required standard in some respect only

Emotional and specialist support
There was evidence on the files of key working being completed and recorded by some of the four full time staff. These records evidenced structure, care and support for the young people. The majority of the core file paperwork was being completed by the assistant project leader and one or two other staff. They identified support for education, promoting young people to use their day supports, accessing EPIC, local resources and creating CV's for example. The staff linked to hospitals in critical situations, they were assisted by Out of Hours social workers where necessary. The staff also did key working that promoted GP visits with the young people to look after their general health.

The files contained information regarding the day supports available to the young people, their important persons and professional visitors. There was evidence of some allocated social workers being involved in providing information, supports and move on for the young people. As stated the care records/files did not contain sufficient details around their placements and this requires on-going improvement. Despite the improvements in the systems on the files the inspector found that there were deficits in the tracking of information on medical conditions, specific learning difficulties, mental health and disabilities. The management of and advice for staff around same was not clearly visible or detailed enough, where necessary, on the files. The recording of medication and its administration required attention also.

3.5.3 Practices that did not meet the required standard

Suitable placements and admissions

The admissions processes were not comprehensively recorded but planning meetings were held to address planning and risk for young people. The records on file were not detailed and plans therefore were unclear. Similarly there were communications daily with the Out of Hours / Crisis Intervention Services day team as well as the night time social workers but records maintained of these also varied in standard. It was clear that mutual co-operation and communication was in place between the Crisis Intervention Services, the Out of Hours social work team and the centre. Areas of difference did arise regarding gate keeping on admissions but the lack of records impacted the inspector's ability to review the actions in place to manage this appropriately. There were also meetings taking place involving the young people's social workers although these became difficult where a social worker was from outside the Leinster region in particular.

By the time of this inspection visit it was clear from the register that a group of young people had experienced re-admissions and several were staying or had stayed in the centre for up to three months. This far exceeded the purpose and function of the centre and represented a burden on vulnerable young people at a difficult time in their lives. Out of a total of twenty two young people six had more than one admission to the centre, at least three of these had three or more admissions. From the inspectors review, on approximately twelve occasions young people left within the three days stipulated in the purpose and function but often this was to another emergency placement in the Child and Family Agency crisis intervention service. Some of these twelve young people were also readmitted. A small cohort of young people was using the placement for over one, two and three months at a time. Two young people who met with the inspector explained clearly the impact on their lives

of living without a stable base although they were complementary about the centre and the care they provided. They asked what the Child and Family Agency were doing to meet their needs, they specifically asked why was it ok "to live like this". There was evidence of some social workers staying actively in phone and email contact with the centre and the young person. There was also evidence of some aftercare planning and meetings but the centre does not represent a place from which any young person should have to approach leaving care. The management expressed their concern regarding a small cohort of young people turning eighteen whilst at the centre and of another small cohort of young people being placed in the inner city from the countryside. Both the young people as stated named to inspectors that although they respected the team that the impact on their lives and their well-being was substantial. One had a stable placement sourced and the second young person was worried about getting a place to live.

The inspector found that the management team had introduced risk assessment and risk management tools as committed to in the action plan. They sought crisis management plans from previous placements where available to allow them to rapidly identify risks. They also sought to maintain a system of risk assessment, review and management from admission to discharge. On the three files reviewed by the inspector there was evidence of risk management systems but these had not been reviewed and updated with the intended regularity or in response to changes . The three young people at this time had been residing at the centre for nearly three months in two cases and several weeks for the third. The Principal Social Worker for the Out of Hours social work team stated that the night social workers had access to the National Child Care Information System database and that they could share information to support good risk assessment and rapid decision making around admissions and group mix. There had been an agreement with the Out of Hours team that they would visit the centre once a week and this had not fully established in practice as yet and should now be prioritised. The inspector found that the young people had questions and that access to Tusla social work staff would be of benefit to them. This would also be directly relevant to and supportive of good risk management and safeguarding at the centre.
The action plan responses relevant to admissions and risk management had been partially achieved.

3.5.4 Regulation Based Requirements

The centre did not meet the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) 1996***

-Part III, Article 17, Records
-Part III, Article 10, Health Care (Specialist service provision).

Required Action

- The organisation must resource and support the centre in their ongoing improvements regarding systems and record keeping for admissions and risk management.
- The Child and Family Agency must co-ordinate actions to ensure that the young people have a full social work service reflective of the emergency nature of the placement.

3.7 Safeguarding and Child Protection

3.7.1 Practices that met the required standard in full

None identified.

3.7.2 Practices that met the required standard in some respect only

Standard
Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

The situational risk assessment had not been completed to account for the co-location for adult and children services. The project leader and assistant project leader stated that they had a good working relationship with the next door hostel and with the local area Community and Child Protection Gardaí and that these were the protective factors in place. They stated that they believed that the risk was based on inaccurate information but the inspectors find that the situational risk assessment be completed as standard given the on-going co-location of two services for vulnerable persons.

The assistant project leader stated that the young people were spoken with about safety regarding the next door hostel but that this was not formal nor is it part of their induction. A young person highlighted to the inspector their discomfort with the centres position next door to an adult service. The situational risk assessment must be completed.
The action plan response had not been achieved.

Child Protection

Standard

There are systems in place to protect young people from abuse. Staff are aware of and implement practices which are designed to protect young people in care.

The assistant project leader stated that the staff had completed the required national e-training in Children First and also on the organisations child safeguarding and child protection policies over two days.

There was one child protection and welfare reporting form/CPWRF on file and this was not noted on the SEN register. The centre must establish a child protection reporting register and tracker. The notification was reported through the appropriate mechanisms and the management should complete the record through to outcome and add to the child protection register. There had been one child protection report identified as necessary since the response to the last report.
The action plan response had been achieved.

3.7.3 Practices that did not meet the required standard

None identified.

Required Action

- The organisation must establish a child protection register and child protection oversight system.
- The organisation must ensure that a risk assessment is completed to address vulnerable service users interacting with adult services in the locality.

3.10 Premises and Safety

Standard

The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

3.10.1 Practices that met the required standard in full

Fire Safety

Actions had been taken to address completion of fire safety checklists in accordance with the centres fire safety guidelines. The two audits completed reviewed fire safety.

3.10.2 Practices that met the required standard in some respect only

None identified.

3.10.3 Practices that did not meet the required standard

None identified.

3.10.4 Regulation Based Requirements

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996, Safety) Part III, Article 13, Fire Precautions***

4. Action Plan

Standard	Issue Requiring Action	Response with Time Scales	Corrective and Preventive Strategies To Ensure Issues Do Not Arise Again
3.2	The organisation must urgently act to create a renewed strategic plan and responses to the regulatory compliance issues in care and operational practices and staffing.	The Director of Services, Services Manager and Project Leader will implement a comprehensive strategic plan for the service to address the regulatory compliance issues in care and operational practices and staffing. **Actions Taken:** A new reconfigured roster has been developed that will provide the required staff cover and will facilitate management oversight of care practices, supervision and adherence to all administrative requirements. The new roster will be operational by end Q1. Contact Worker grades have been replaced with Project Worker grades and recruitment of new grades will commence immediately. One additional, dedicated Project Worker relief post has been introduced to support	The risk register will be updated in relation to governance, compliance and operational risks. All actions to address identified risks, as outlined in this action plan, will be recorded, as will any comments by the Board. This will be completed by end of January 2020. Review of new roster at 6 months to ensure that it is meeting the needs of the service. Ongoing monitoring of staffing capacity. Any issues reported immediately to senior management and Human Resources and corrective actions taken to ensure levels maintained. The management will review personnel files bi-annually. In collaboration with the Services Manager and Project Leader, the Services Standards Officer will devise a new audit tool for use by the Services Manager on a monthly basis. This will be in place by the end of

		a consistent staff complement. **Planned Actions:** The Case Management team (3 x Project Workers) will be integrated into the new roster and provide case management support on-site on Monday to Friday. The Extension Day Service will move from the premises in early 2020.	February 2020. The Services Standards Officer will carry out an additional audit function on a quarterly basis. All completed audit documents will be filed on-site. Actions arising from audits will be actioned, time-framed and implemented by Project Leader and Assistant Project Leader. Formal supervision of all staff members will take place every 4-6 weeks, in line with Focus Ireland's supervision policy.
	The organisation must provide the centre with a set of policies, procedures and working tools that support the purpose and function of the centre and are reflective of the National Standards for Children's Residential Centres (HIQA 2018), relevant regulations and legislation.	A complete review of the service's policies and procedures has commenced to ensure compliance with HIQA standards and relevant regulations and legislation. This will be completed by end of January 2020.	Focus Ireland's Services Standards Officer has been assigned to lead a review of the policies, procedures and tools to ensure compliance. This has commenced and will be completed by the end of Q1.
3.5	The organisation must resource and support the centre in their ongoing improvements regarding systems and record keeping for admissions and risk	The reconfigured roster will introduce new shift patterns which will incorporate an overlap of the management function within shifts and between shifts. This will greatly	Care files/records will be reviewed by management and the team will be supported to ensure that all files are organised properly, contain the required

	management.	improve administrative oversight, risk management as well as the daily support and supervision for the team. The new roster will incorporate dedicated time for the management to review current practices and to monitor admissions, risk management and care planning	information and are updated throughout placements to reflect the plans for each young person and progress towards achieving stated outcomes. This will be completed by the end of January 2020. Care files will be monitored on an ongoing basis by management to ensure compliance (daily supervision and monthly/quarterly audits – see above). The staff team will be provided with guidance about how care files should be arranged and maintained and what information they should contain. Team meetings will take place weekly, at which reporting and recording will be addressed to ensure compliance. Admission processes will be reviewed and new recording templates introduced that outline plans for each young person admitted, detail identified risks (if known) and record actions to address same. This will be completed by the end of January 2020. Risk management processes will be reviewed, including the risk assessment template and risk management tools. Risk
	The Child and Family Agency must co-ordinate actions to ensure that the young people have a full social work service reflective of the emergency nature of the placement.	Management will continue to advocate for social work support and advocate for clear move-on plans for each admission so that the service can operate in compliance with its stated purpose and function.	

			will be monitored by management on an ongoing basis and reviewed at daily handovers and team meetings. This will be completed by the end of January 2020. Focus Ireland met CIS/OOHs on the 3/12/19 to discuss the referral and admission process, bed management and the management of risk. A new protocol was agreed which aims to improve communication, improve gate-keeping and mitigate risk. We are awaiting a first draft of the protocol following this meeting. Changes to risk profiles will be addressed, escalated to senior management, if necessary, and recorded in case files. SENs will continue to be reviewed regularly by management to improve consistency in reporting, track numbers and frequency and to identify recurring themes and/or risks which may require additional actions or escalation. Management will seek written guidance from Social Work departments regarding individual needs and risks for each admission. Focus Ireland will request, in writing, that

			OOHs visit the centre once a week, as previously agreed, to address any issues arising and to provide social work support to young people, as needed. If placements exceed the 3-day limited, the management will seek a formal meeting with social work to discuss a move-on plan. Lack of social work engagement will necessitate an escalation to senior Tusla management.
3.7	The organisation must establish a child protection register and child protection oversight system. The organisation must ensure that a risk assessment is completed to address vulnerable service users interacting with adult services in the locality.	The Project Leader will introduce a system to register and track CPWRF's. A Situational Risk Assessment will be carried out immediately to address the issue of the co-location of the service next door to a hostel for vulnerable adults.	A dedicated SEN book will be used to record and track CPWRF's. Each report will be recorded and the reference number noted. The printed CPWRF and the acknowledgement of receipt of same by Tusla area will placed on each young person's file. The Project Leader will follow up with Area Social Work Department where appropriate or necessary. This will be in place by the end of January 2020. An appropriate assessment tool will be used to carry out this assessment. Any risks identified will be recorded and actions will be taken to address/mitigate risks. Actions will be recorded and time-lined. This risk assessment will be carried

			out annually and the action plan amended accordingly. This will be completed by the end of January 2020.