An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 112

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced – blended**
Date of inspection:	**25th & 26th February 2021**
Registration Status:	**Registered from 17th May 2019 to 17th May 2022**
Inspection Team:	**Catherine Hanly** **Linda McGuinness**
Date Report Issued:	**7th May 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 17th of May 2016. At the time of this inspection the centre was in its second registration and was in year two of the cycle. The centre was registered without attached conditions.

The centre was registered to provide medium to long term care to a maximum of four young people aged between thirteen and seventeen years of age. The centre had a model of care described as the systemic therapeutic engagement model (STEM) which was reported to provide a framework for positive interventions with young people through four distinct aspects to the STEM model: belonging, mastery, independence and generosity. The model was based on a number of complimentary philosophies and was described as a strengths-based approach that focused on working relationships and resilience of young people. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3 only
3: Safe Care and Support	3.1, 3.2, 3.3
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make. Due to risk assessments undertaken by inspectors relating to the Covid-19 pandemic, this was a blended inspection consisting of remote and onsite inspection activity.

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 30th of March 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 14th of April. 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: 112 without attached conditions from the 17th of May 2019 to the 17th of May 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The centre can accommodate up to a maximum of four young people and inspectors found that the layout of the premises was suitable for providing safe and effective care for them. Each young person had their own bedroom and there were adequate and suitable storage facilities for their respective personal belongings. Bathroom facilities were sufficient and ensured privacy. The property was situated on its own private site and had a large indoor ground floor area with generously sized communal areas and recreational facilities both inside and out. A variety of recreational resources had been purchased on an ongoing basis for both internal and external use according to young people's individual interests and hobbies. The inspectors found that the premises were clean, appropriately decorated and maintained in good structural condition. It was adequately lit, ventilated and heated. Inspectors did note that the matter of zoned heating within the centre had been raised on a number of occasions in maintenance checks and records and there was no resolution recorded. The registered proprietor must ensure that this matter is resolved.

Young people had the opportunity to be involved in the decoration of the premises and their individual bedrooms. Inspectors did query the use of organisational stickers within the centre as the young people resident had identified these as something they were unhappy/uncomfortable about. The use/display of these stickers should be reconsidered in the context of creating a homely environment and taking the views of the residents into consideration.

Compliance with fire safety legislation, relevant building regulations and health and safety legislation had previously been submitted and approved for the purpose of this centre's renewal of registration in 2019. Inspectors noted that the septic tank had

been most recently emptied in July 2020 in response to the centre manager highlighting the need for same with the Director of Operations. Whilst this matter was responded to promptly by senior management, when the issue was highlighted the toilets were not flushing properly and the septic tank content was already backing up into external drains posing a health and safety risk to anyone on the property. This was not however recorded as a possible health and safety risk by management with identified control/mitigation measures implemented. The Director of Operations confirmed with inspectors that this matter will be kept under review. Centre management must ensure that a regular schedule of auditing the septic tank and sewerage system is undertaken and documented in order to escalate any issues at an early stage so that they may be responded to appropriately.

Regular audits of all vehicles used to transport young people were undertaken to ensure that these vehicles were roadworthy. The vehicles were regularly serviced and were insured. The centre's safety statement specified that only full license holders, over the age of 23 were permitted to drive company cars. There were procedures in place for managing risks to the health and safety of staff and visitors outlined in the centre's safety statement and where accidents/incidents occur these were recorded and reported appropriately.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified – not all standards examined**
Practices met the required standard in some respects only	**Standard 2.3**
Practices did not meet the required standard	**None identified – not all standards examined**

Actions required

- Centre management must ensure that the zoned heating issue is resolved.
- Centre management must ensure a regular audit of the sewerage and percolation system is undertaken.

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.

The centre had policies and procedures in place, in line with Children First and relevant legislation, to protect young people from all forms of abuse and neglect. During this inspection, centre management submitted a revised child protection policy document to inspectors for their review and this had been amended to reflect feedback from inspectors in some of the organisation's other centres. It was the intention of centre management to share this revised document with the entire staff and management teams across the organisation for familiarisation and implementation. The registered proprietor had systems of governance and oversight in place which ensured that the centre operates in line with the relevant policies and legislation. The acting manager was identified as the Designated Liaison Person (DLP) for this centre and the registered provider was the DLP for the organisation. The regional manager confirmed that the acting manager had been enrolled on a training course for the DLP role.

The centre had a bullying policy and procedure in place and the management and staff team stated that there were no incidents of bullying amongst current residents. Inspectors recommend that this policy be reviewed and amended to include specific reference to possible exploitation of young people on the internet and through their use of social media. The policy stated that bullying would be a regular feature for discussion at both young people's and staff team meetings, as well as a coordinated piece of work being conducted with young people periodically throughout each year. Inspectors found evidence in individual work records and young people's meeting minutes of discussions with the young person on the subject matter of bullying and negotiating interpersonal relationships.

Staff in the centre demonstrated a good understanding of the various safeguarding policies and procedures in place and there was evidence that good practices including the use of risk assessments, liaison with management and social workers where necessary, as well as vetting and induction for staff were being implemented. The manager and staff team had completed the Tusla E-Learning module: Introduction to Children First in addition to child protection training provided by an external company. There was evidence that a partnership approach, involving young people,

their parents where appropriate and social workers was prioritised at the centre. The centre had a Child Safeguarding Statement that had been approved by the Tusla Child Safeguarding Compliance Unit, that detailed the presenting risks to young people and staff were familiar with the content of this statement. The regional manager confirmed that they would update this statement to reflect the change of named manager.

The pre-admission risk assessment process identified individual vulnerabilities for young people and informed individual work that the staff team had subsequently undertaken with them during their placement in the centre. In addition, ongoing risk assessments undertaken as required influenced the implementation of individual safeguards which were recorded and reviewed on a regular basis. Inspectors found that young people were encouraged by the staff team to speak out and have their voice heard with regard to all aspects of their care. Parents were informed of any incident or allegation of abuse.

The centre had a policy and procedure on protected disclosures and staff were familiar with this. Staff were confident that they could raise any issue of concern within this centre with any member of management without fear of adverse consequence. However, in practice Inspectors noted that staff had raised concerns with their centre manager regarding some aspects of risk assessment processes whilst working in other centres within the organisation. They did state that they were wary of bringing conflict as a result of raising such concerns in the centre that it related to. These concerns had not been escalated beyond the team meeting forum and should have been in order for management to address the matter. Senior management must ensure that the practice of raising concerns is consistently encouraged and appropriately responded to across the organisation.

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

The acting manager and staff in the centre described various aspects to their approach in the management of behaviour that challenges including the use of praise, reward and incentivised programmes targeted at encouraging positive behaviours. However, inspectors found that the staff team could not consistently describe a standard centre-led positive approach to managing behaviour that challenges. The centre had a number of policies and procedures related to this area of practice including a sanctions policy and a policy on the use of engaging An Garda Síochána. Senior management must review the relevant policies and develop and implement an

overarching policy that ensures the provision of positive behavioural support and incorporates all existing relevant policies and procedures.

There was some evidence that staff utilised their relationship with young people and were guided on occasion by the centre's model of care in providing positive behavioural support to young people to manage their behaviours. The staff team were attuned to the individual needs of young people and understood the impact of their personal experiences on their presenting behaviours. The centre does not have access to specialist support/direction from within the organisation but where young people were linked with external services, there was good input with young people directly and also guidance and direction available to the staff team. Notwithstanding this level of knowledge, one social worker highlighted with inspectors their view of the need for the staff team to appropriately challenge the behaviours of one young person in a supportive way in order to develop their coping skills. This is particularly in light of their age and preparing them for independence. The acting manager should pursue appropriate direction from the relevant clinical services available.

The staff team demonstrated a clear understanding of restrictive procedures and there was evidence of the use of these being recorded. Restrictive procedures were used rarely and with clear purpose and review. Behaviour management plans for young people were informed by referral information initially and were reviewed and updated throughout a young person's placement reflecting relevant changes and known behaviours of the young person. Staff members did not refer to these plans when discussing the area of behaviour management with inspectors and this should be considered within the context of the development of an overarching policy on the management of behaviour.

Inspectors found that one young person's individual crisis management plan (ICMP) was contradictory in its identification of the use of approved physical interventions. This must be clarified and clearly documented on the record. The staff team were provided with training in the use of physical interventions where necessary with young people. Although this training was updated regularly, the Covid-19 pandemic had impacted on the physical aspect of this training. The acting centre manager must clarify with the relevant trainers whether or not the staff team are deemed to be certified to use such interventions currently. If not, this should be reflected on individual crisis management plans for young people.

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

Inspectors found that an open culture was promoted whereby both young people and staff were encouraged to raise concerns, report incidents and identify any areas for improvement or development. This was evidenced across meeting and handover records as well as at senior management level. There were consultation forums for staff that participation in was frequently encouraged and there was evidence across many records reviewed of the expression of the young person's voice. Regular communication and meetings with social workers and parents allow for feedback from those persons. As noted earlier in this report, this open approach to providing and receiving feedback should be consistently encouraged and realised across the agency.

The centre had a detailed significant event policy that inspectors found was realised in practice. There was a clearly understood and implemented system for the recording, reporting, management and review of all incidents that occurred in the centre. The acting manager was responsible for ensuring that incidents were reported and recorded in a timely manner. Inspectors were informed that the escalation of incidents to senior manager is a matter of professional judgement. Senior management must continue to ensure that the necessary support, guidance and direction is afforded to the acting manager as they develop within their role with regard to the reporting of incidents. The review of incidents took place on a regular basis at significant event review group, in accordance with policy, and feedback and areas of learning from this review was shared with the staff team. One social worker did raise with inspectors that there had been some deficits in communicating incidents to their office and that this had been raised with the centre and subsequently addressed. The acting centre manager, and senior management through their auditing systems, must ensure that all incidents continue to be reported within the prompt timeframes outlined in centre policy.

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

- Centre management must revise and amend the policy document on anti-bullying to include reference to bullying in the context of the internet and social media.
- Senior management must ensure that all grades of staff across the organisation are confident in reporting any matter of concern that relates to practice in any centre.
- Centre management must develop and implement a policy that guides a positive approach to managing challenging behaviour in the centre.
- Centre management must clarify the training status of the staff team in relation to the use of physical intervention and document this accordingly on the relevant records.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found evidence of centre management regularly undertaking workforce planning at senior management meetings. These discussions had a focus on forward planning for relief staff, cover for all types of leave and the replacement of staff where resignations were known. A significant aspect of these discussions was the retention of staff, including the creation and implementation of rewards as a gesture of appreciation, paternal leave and financially supported health benefits. The stable

staff team in this centre was a recurring theme highlighted to inspectors which had provided young people with a notable period of continuous consistent care.

At the time of the inspection, the staff team comprised the acting manager, two social care leaders and five social care workers. The acting manager had previously been the assigned deputy manager for this centre since February 2020. They had commenced in the capacity of acting manager in November 2020, initially to cover sick leave and this had been incrementally extended until a defined period of cover in the role of acting manager was confirmed. Following the inspection, this would extend to cover maternity leave. One full time social care worker had resigned from their post immediately prior to this inspection and a recruitment process had commenced. The core staff were supported by one identified relief staff member. There was a mix of qualification and level of experience amongst the staff team, including relief staff member, with only four of the fulltime staff team having a social care qualification. Inspectors found that the staff team demonstrated the necessary experience and competencies to meet the needs of the young people in the centre. Whilst inspectors did not find any deficits in relation to the care being provided to young people, the numbers in the centre were less than that specified in the centre's Child Safeguarding Statement which stated that the centre had one manager and nine care staff and were also less than the minimum number specified in both the centre's Service Level Agreement with Tusla and the minimum numbers specified (eight social care staff) in the memo issued by the Alternative Care Inspection and Monitoring Service (ACIMS). The centre were operating for a period of time with only one resident and had admitted a second young person a matter of months before this inspection was conducted. Should the centre be operating at full capacity, they would not have sufficient staff to meet the needs of all young people and the centre's statement of purpose. Senior management confirmed that interviews were being conducted the week following this inspection. Centre management must ensure that the required numbers of staff are employed for this centre.

Standard 6.2 The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

The centre had a written policy on recruitment that was informed by relevant national guidelines but did not include reference to the National Vetting Bureau (Children and Vulnerable Persons) Act 2012-2016. The policy must be reviewed and amended to ensure that vetting practices undertaken by the organisation are in compliance with this legislation.

The registered provider had recruited staff with a range of qualifications, skills and competencies to work in the centre. Four of the full time staff team had a social care qualification. Remaining members of the full time team did not have a social care or relevant equivalent qualification but three had made commitments to returning to formal education in September 2021 to attain a recognised qualification. Some of those staff members without a social care or relevant other qualification had been recruited contrary to the direction included in the memo on staffing which was issued by the ACIMS in February 2020. Inspectors noted that skills and experiences were shared at a team level furthering their development. Senior management were cognisant of the need to maintain a balance of staff qualification cross the team in ongoing recruitment campaigns. Staff members had written job descriptions and contracts specifying the terms and conditions of their employment. Personnel files were maintained securely at a central location and were made available at the centre for inspector's review.

The acting manager had a social care qualification and had the required level of post qualification to fulfil this role. They had limited experience at deputy manager level and the regional manager had identified areas of learning and development for the new role of manager which they would oversee formally. Inspectors noted that the acting manager had not been provided with a job description for the role. The Director of Operations confirmed that this would be provided and also indicated that a cover note would be added to their contract specifying their change of post from deputy manager to acting manager for a specified interim period.

The centre had a detailed code of practice that identified the principles that guided their work. Inspectors found through interview, questionnaire and review of records that this policy was being realised in practice.

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

Staff in the centre were able to clearly demonstrate their understanding of, and talk about, their respective roles and responsibilities. There was a clear accountability and reporting structure evident and staff demonstrated good working knowledge of the policies and procedures that informed their work. Team meetings, daily handovers and the practice of shift reflection enabled a team-based approach and a collective accountability in the provision of an effective service that was young person-centred. Staff were encouraged through supervision, handovers and team

meetings to exercise their professional judgement and to liaise with their colleagues in decision-making.

The centre's safety statement identified the various measures and procedures in place to protect staff and minimise the risk to their safety. This was comprehensive and included risk assessments of property and activities; safe use of vehicles; supervision and support; and ongoing staff training across all relevant areas. The centre's policy document made reference to a safety committee whose purpose was to consult and assist on all matters relevant to health, safety and welfare. The acting manager confirmed that there was no such committee in practice and that safety matters were discussed at both team and management meetings and inspectors viewed evidence of same. The policy should be reviewed and updated to reflect practice in the centre.

The staff team described a learning culture in the centre and inspectors noted that individual personal development plans were implemented to encourage the development of skills and practices where necessary. There was evidence that reflective practice was a prioritised tool in use which further supported learning and development amongst the team. Some staff members had qualifications and other training outside of social care and there was evidence that this had been shared within the team to enhance each other's practice. There was evidence that the team were open to questioning one another and raising issues regarding consistency in practice as necessary. One area of difficulty that had been highlighted within team meetings and by some staff members was communication. Both social workers also stated that communication had been problematic on occasion, particularly within recent months, and that they had had to raise this with the acting manager. The acting manager and regional manager must continue to have oversight of communication systems within the centre and of exchanges with professionals outside of the centre and in doing so satisfy themselves that it is clear, meaningful and effective.

The centre had a detailed supervision policy that described a three-pronged approach to this practice, namely accountability, case supervision and professional development. Inspectors found that supervision was taking place regularly in accordance with the timeframes and focus identified in the policy. Inspectors did note that detail within these records was on occasion limited and non-specific, referring for example to the need for "professional practice". It would be more constructive for both parties, and the regional manager tasked with oversight of this practice, if more specific detail was provided so that issues identified could be more easily tracked to ascertain whether further or alternative action was required. The

supervision policy detailed the level of support provided through the process of supervision and it is through that forum that the need for, and format of, any necessary additional supports would be identified. The centre does not have a formal employee assistance programme, but all staff expressed that they were supported both formally and informally in many ways including through supervision, access to management, financial support for training and education, and financial assistance for healthcare. It would be beneficial to formalise all such supports in an overarching policy.

The centre had a policy and procedure on formal appraisals that was realised in practice. These were conducted on a yearly basis with management and a record of these meetings and agreements made within them were maintained.

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

The oversight of the training and education of the staff team was covered in the centre's clinical governance policy. Regular audits of training had been conducted throughout 2020 however despite the identification of refresher training being required, the Covid-19 pandemic had impacted on the delivery of training. There was evidence of discussions regarding training needs within individual supervision and at team meetings and these various mechanisms helped to ensure that ongoing training and education of the staff team remained a focus. Individual personal development plans had been developed on occasion as need had arisen, although this was not standard practice for all staff. Records of these were maintained by the acting centre manager and reviewed on an ongoing basis until they had been realised. Inspectors were provided with a copy of the staff training record and found that whilst mandatory training including child protection and fire safety as well as training in the model of care used in the centre had been completed, much of this was over two years old. Inspectors noted that timeframes for refresher training are not included in the centre's policy on training and this would be a purposeful amendment.

A number of staff had committed to continuing their formal education in recognised social care courses commencing September 2021. The organisation was committed to supporting staff financially and in facilitating their academic schedule to enable them to attend these education courses.

The centre had a formal induction policy that inspectors found had been realised in practice.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**Standard 6.4**
Practices met the required standard in some respects only	**Standard 6.1** **Standard 6.2** **Standard 6.3**
Practices did not meet the required standard	**None identified**

Actions required

- Centre management must ensure that the requisite number of staff are recruited for this centre, these staff must hold the specified qualifications and the specified minimum levels of staff must be maintained at all times.
- Centre management must review and update the policy on recruitment to ensure that is it compliant with relevant legislation.
- Centre management must review the policy on health and safety and ensure that it reflects practice in the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	Centre management must ensure that the zoned heating issue is resolved.	Zoned heating issue highlighted in report, has been rectified following call out on 14/12/2020.	Regular checks of the heating system will be carried out by staff onsite, and oversight will be provided by centre management. The centre's boiler will be serviced annually, or sooner as required. Health & Safety Audits to be updated to include these specific records. Action date 6th May 2021.
	Centre management must ensure a regular audit of the sewerage and percolation system is undertaken.	DCS Maintenance Team will be scheduled periodically to conduct regular audit of sewerage and percolation. External works will be sourced if any future issues cannot be rectified by DCS maintenance.	Audit of sewage and percolation to be added to maintenance annual schedule.
3	Centre management must revise and amend the policy document on anti-bullying to include reference to bullying in the context of the internet and social media.	Senior Management will review anti-bullying policy on 27th May 2021 in the context with internet and social media and potential exploitation via these platforms.	Policy will be reviewed every 2 years, or as necessary.

	Senior management must ensure that all grades of staff across the organisation are confident in reporting any matter of concern that relates to practice in any centre.	Complaints Procedure Powerpoint completed with centre team on 18/3/2021, Centre Management to review Protected Disclosure Policy in team meetings on 23/04/21. Periodic audits of staff's confidence in reporting matters will be carried out via the Quality Assurance Team.	Centre management will utilise centre's self-audit tools to identify areas for improvement. Quality Assurance audits inclusive of qualitative interviewing with staff will assist with informing confidence levels.
	Centre management must develop and implement a policy that guides a positive approach to managing challenging behaviour in the centre.	Senior management to develop and implement an overarching policy that encompasses managing challenging behaviour with emphasis on using positive approaches incorporating existing policies and STEM model of care. Policy will be developed for review on 27th May 2021 and communicated to staff via team meetings and supervision.	Policy on the Provision of Behavioural Support will be developed and communicated 27th May 2021.
	Centre management must clarify the training status of the staff team in relation to the use of physical intervention and document this accordingly on the relevant records.	YP documents have been reviewed to confirm that physical restraint is not supported or approved. Training audits have been reviewed and document staff's level of TCI training.	Regular review of training audit to be conducted/updated with levels specified.

6	Centre management must ensure that the requisite number of staff are recruited for this centre, these staff must hold the specified qualifications and the specified minimum levels of staff must be maintained at all times.	Requisite numbers have been appointed to the centre in line with national requirements and all newly appointed staff have appropriate qualifications in line with R&I memo of Feb 2020. Centre and regional management are supporting other staff to secure the requisite qualifications as per Feb 2020 R&I memo.	HR department to ensure all candidates have the specified minimum qualification at pre-screen stage, prior to arranging interviews. Pre-screens are also reviewed by regional managers to fully satisfy that all queries related to qualifications are met prior to interview process. Staffing levels are monitored and communicated through centre governance and HR reports and are discussed at senior management meetings.
	Centre management must review and update the policy on recruitment to ensure that is it compliant with relevant legislation.	Policy on recruitment is to be updated by Senior Management Team (27th May) to reference the NVB's Children's and Vulnerable Persons Act (2012-2016) legislation to ensure compliance.	Recruitment Policy to be reviewed by Senior Management Team and policy to be detailed and explicit in terms of compliance with legislation and shared with HR department to ensure requirements are upheld.
	Centre management must review the policy on health and safety and ensure that it reflects practice in the centre.	Health and safety policy was reviewed by centre management at team meeting and is a standing item on agenda for discussion on a fortnightly basis. Centre Manager to review and provide oversight of practice by reviewing health & safety on a daily basis, conducting audits and accurately reflecting	Health and safety forms part of the centre's governance report which are reviewed by the senior management team. Reviewed regularly by quality assurance led audit to ensure policy is reflected through centre practice.

		practice via addressing issues in supervision, team meetings, management meetings, and handover meetings. Issues and progress will be reported and overseen through fortnightly governance reporting to senior management.	