An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Registration and Inspection Service

Children's Residential Centre

Centre ID number: 055

Year: 2018

Lead inspector: Noreen Bourke

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Registration and Inspection Report

Inspection Year:	**2018**
Name of Organisation:	**Fresh Start**
Registered Capacity:	**Four young people**
Dates of Inspection:	**20th and the 21st of February 2018**
Registration Status:	**Registered from the 5th May of 2016 to the 5th of May 2019**
Inspection Team:	**Noreen Bourke**
Date Report Issued:	**16th of July 2018**

Contents

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 on-going 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 on-going 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 2016. At the time of this inspection the centre were in their first registration and were in year two of the cycle. The centre was registered without conditions attached from the 5th of May 2016 to the 5th of May 2019. The centre relocated to a new premise in October 2017.

The centres purpose and function was to accommodate four young people of both genders from age twelve to seventeen years on admission. The centre does not prescribe to a specific model of care. Their mission statement stated *'the young people's individual needs may require that we provide innovative and radical services. These will be provided on an informed, planned and well-considered basis'*.

The inspectors examined standards 1'purpose and function' 2 'management and staffing' 4 'children's rights', aspects of standard 6, 'care of young people' and 7 'safeguarding and child protection' and 10 'premises and safety' of the National Standards for Children's Residential Centres (2001). This inspection was announced and took place on the 20th and the 21st of February 2018.

1.2 Methodology

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

- An examination of pre-inspection questionnaire and related documentation completed by the Manager.

- An examination of the questionnaires completed by:

a) Four of the permanent care staff, and two relief staff.
b) One of the social workers with responsibility for young person/people residing in the centre.

- An inspection of the premises and grounds using an audit checklist devised by the Health and Safety and Fire and Safety officers of HSE on our behalf.

- An examination of the centre's files and recording process.

  Personnel files
  Supervision records
  Record of team meetings
  Centre register
  Significant event log
  Complaints log
  Sanction log
  Staff training log.
  Handover book
  Care files
  Young people's house meetings.
  Fire register
  Health and safety statement

- Interviews with relevant persons that were deemed by the inspection team as to having a bona fide interest in the operation of the centre including but not exclusively

  a) The centre management
  b) The clinical manager
  c) The operations manager
  d) Two staff

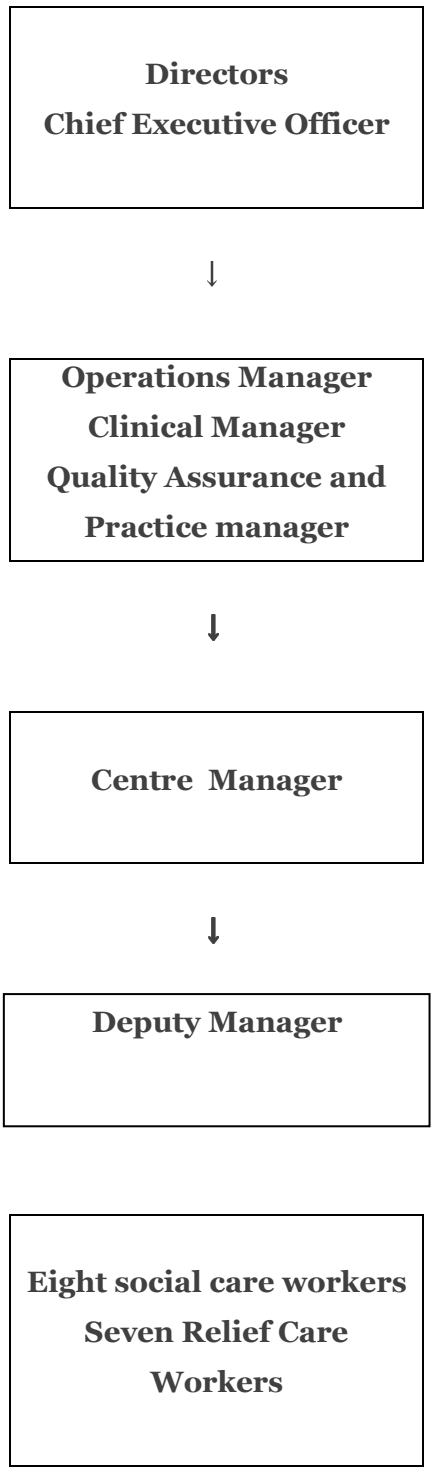
e) The two young people
f) One of the placing social workers

- 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 service manager, and the relevant social work departments on the 18th of May 2018. 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 centre manager returned the report with a completed action plan (CAPA) on the 2nd of June 2018. The inspection service liaised with the centre to seek clarification on some of the responses; was satisfied with the clarifications given and the inspection service received evidence of the issues addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 055 without conditions attached from the 5th of May 2016 to the 5th of May 2019 pursuant to Part VIII, 1991 Child Care Act.

The period of registration being from the 5th of May 2016 to the 5th of May 2019.

3. Analysis of Findings

3.1 Purpose and Function

Standard
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

3.1.1 Practices that met the required standard in full
None identified.

3.1.2 Practices that met the required standard in some respect only

The centre had a written statement of purpose and function. At the time of the inspection the wrong purpose and function statement was provided to the inspection service, which was later rectified. The inspection service urge the service to ensure the correct and updated statement of purpose and function is consistently provided to those requesting it. The correct statement described the centre as providing short to medium care for four young people, aged from 13 to 17 years on admission and of both gender. The statement of purpose and function was reviewed on an annual basis by the centre manager, the operations manager and chief executive officer and was last reviewed in January 2018.

The statement was available in a user friendly form to both parents and young people. The statement lists the key policies in place at the centre. The statement made reference to the provision of individual therapeutic programmes of care to meet the specific needs of the young people. These programmes of care were based on the assessed needs of the young people. In interview with senior management the findings of the inspector were that they had different understanding about the care programme operated by the centre. In one case it was described as being informed by the theory of attachment and trauma. In another it was also described as being 'nonspecific'. The approach to care was not referenced in the centres written information or evidenced in training provided to staff. The service must be clear about the programme of care it delivers and that this is understood by all staff.

3.1.3 Practices that did not meet the required standard
None identified.

Required Action

- The chief executive officer must ensure that the information provided in its statement accurately describe the specific care approach used by the centre. Staff must be familiar with the care programme of the centre

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

The centre manager maintained a register of all children who lived in the centre to date. The centres register of admissions and discharges were accurate and up to date. There were five admissions and three discharges to the centre since the last inspection. There was a system in place where duplicate records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

Notification of Significant Events

The centre had a notification procedure in place that provided details in writing of significant events relating to the young people. The social worker interviewed confirmed to the inspector that they received prompt notification of significant event reports; they were also notified by phone prior to receiving the written report in the event of the incident being serious. Significant event reports were on file at the centre. Copies of all reports were held in the care file of the young people.

The reports were reviewed by the centre manager and where necessary they were reviewed in staff supervision and at team meetings. External oversight of the reports is provided by the designated TCI monitor for the Centre. When it is deemed necessary oversight of the significant event reports is also maintained by the Clinical Manager.

Staffing

The staff team were stable and experienced; there was a good skill mix within the team. A deputy manager and eight social care workers were employed at the centre. They were supported by seven relief social care workers. The inspector found that there were adequate numbers of staff in place to care for the young people.

There were two changes to the staff team since the last inspection in 2016. The inspector examined their personnel files of the newly recruited staff and found the required Garda vetting, qualification; references and verification of references were on file. The files were in compliance with the guidelines on vetting.

The service had in place a staff induction programme. The staff development programme took place over six days, one day per month over six months. New staff attended a half day induction session where they were inducted into the service, i.e. work location, management structure, reporting structures and supervision policy. Staff completed two shadow shifts under the supervision of a line manager and completed the Children First e – learning programme. The induction process was further supported through the process of supervision and this was evident in reviewing their supervision records.

Team meetings were held every two weeks and a review of the team meetings evidenced good attendance by staff. The focus of the team meetings was on the young people, and on the actions required of staff in supporting the placement plans and the individual programmes of care for young people within the process of key working.

Staff handovers took place between work shifts. The inspector attended the handover meetings. A handover sheet recorded the information that needed to be shared with staff. It took account of the presenting issues and plans for the young people. Due to the level of behaviour that challenged within the centre the handover addressed issues of safety for both young people and staff.

Administrative files

The administrative files were examined by the inspector and the key records were in evidence. The service had identified the need for a more cohesive system of recording within their administrative records. They had recently appointed a quality assurance

and practice manager. They were at the initial stages of auditing the administrative files within the centre.

There was good evidence that the manager was monitoring and reviewing the quality of the young people's records. Relevant recording relating to the young people are kept in perpetuity and the management understand the requirements of the Data Protection Act 2003. All historic files are suitably and securely stored.

The centre had clear financial management systems in place. Oversight of the centre budget was maintained by the operations and centre manager. The centre manager stated that the centre had adequate resources.

3.2.2 Practices that met the required standard in some respect only

Management

The centre manager was appropriately qualified and had extensive work experience in residential care. The manager had mechanisms in place to effectively manage the centre. The manager was supported in their role by the deputy manager. The centre manager stated that they had systems in place to oversee the work of the centre. These included oversight of the staff induction programme, staff supervision. Facilitation of team meetings which included a review of significant event reports and of the placement plans for the young people. The manager engaged with other professional and multi-disciplinary team in reviewing the placements. Supervision was consistent, and staff reported that they found the manager to be accessible. Further oversight of the work of the centre was maintained through regional and national management meetings.

The centre manager reported to the operations manager who had responsibility for the oversight of the centre. The operations manager provided supervision to the centre manager. They met with the centre manager monthly along with the centre managers for all other centres within the service. A review of the records of these meetings evidenced that significant events reports for the centre were reviewed. The records also held an account of human resource issues pertaining to the centre.

The inspector found that while there were systems in place to ensure oversight and governance of the centre, however, due to the lack of a clearly defined programme of care, staff were having to deal with young people who presented with a range of complex needs and behaviours that challenged. In some cases the behaviour that

challenged was beyond the capacity of the centre to manage. The inspector found that the external governance of the service did not provide sufficient oversight of the centres purpose and function to take account of the presenting complex needs of the young people who were admitted to the centre. It did not provide enough oversight of staff supervision records, complaints and child protection concerns.

Supervision and support

The service had written policies and procedures on the provision of supervision to staff. The centre and deputy manager were both trained in the delivery of professional supervision. They delivered supervision to the staff team. Supervision contracts were in place for staff. The findings of the inspector were that all staff were in receipt of formal and regular supervision. A review of the supervision records showed that there was a significant difference in the way that both supervisors recorded their supervision sessions. In some cases the records were bullet points which did not evidence how the care plan for the young person was linked to the placement plan. This reflected poor oversight by senior management of the records. This was an issue identified in the previous inspection report dated 2016 and had not been addressed.

The service had a clinical team attached to the service. Staff met with the clinical team monthly. The purpose of these meeting was to review and look at intervention strategies used by the team in supporting the young people. Staff stated that they found these session helpful in giving advice on how to support the emotional needs of the young people and that it supported their existing practice. However, given the complexity of needs of the young people and of the behaviours that challenged the delivery of the clinical programme would be more beneficial if it was delivered in the context of a clear programme of care.

Training and development

The service had an identified training schedule. The staff training records showed that the permanent staff team had received training in first aid, fire safety training, child protection and behaviour management. The training records showed that a number of relief staff required training in first aid, fire safety and behaviour management, and child protection, an issue that must be addressed.

It was evident to the inspector that staff would benefit from further training in how the therapeutic aspect of the programme of care is delivered in reality. The service must be clear that staff understand the care approach envisaged for the centre. Staff

should have an understanding of trauma and attachment and of its relationship to the therapeutic approach.

Staff had available to them the services of a clinical team. The purpose of the clinical teams was to review the clinical care of the young people. They were also available to undertake individual work with the young people such as overseeing their mental health care. The clinical manager together with the clinical team looked at the placement plans for the young people. The clinical manager then meets with the young person's keyworker to give direction as to how the clinical programme was to be delivered to the young person. The clinical manager met together with the clinical team to review individual interventions.

The clinical manager when interviewed described the programme of care as being nonspecific. This was to allow the service to address the needs of the young people as opposed to the young person having to fit into the service and to a specific model of care. This in turn allows the service to work with a diverse group of young people. The findings of the inspector were that this understanding of the programme of care was too diverse. It did not take adequate account of the direction that a staff team require in the delivery of consistent and cohesive care to young people who presented with a wide range of complex needs and in particular behaviours that challenged. Management and staff must have a clearer understanding of the programme of care that they envisage for the centre.

3.2.3 Practices that did not meet the required standard

None identified.

3.2.4 Regulation Based Requirements

The Child and Family Agency has 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 had 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 6, Paragraph 2, Change of Person in Charge
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)
-Part III, Article 16, Notification of Significant Events.

Required Action

- The operations manager must review how supervision is recorded to ensure that the records accurately record the process of supervision.

- The centre manager must ensure that relief staff receive the required training in first aid, fire safety, first aid and staff must be trained in behaviour management before working in the centre.

- The clinical manager must ensure that the program of care being delivered at the centre is clear to both management and staff.

- The clinical manager must ensure that staff are provided with training in the care approached used by the centre.

3.4 Children's Rights

Standard
The rights of the Young People are reflected in all centre policies and care practices. Young People and their parents are informed of their rights by supervising social workers and centre staff.

3.4.1 Practices that met the required standard in full

Access to information

Information provided to the young people informed them of their right to access their information. The keywork reports evidenced that the young people were encouraged to read their records. In speaking with the young people they said that they chose not to read their records. One of the young people interviewed was clear about their care and placement plans.

Consultation

The young people were provided with an information booklet in relation to the centre. Young people were informed of their right to access their record through the booklet. The young people had a forum of house meetings where they could discuss their views and wishes. The inspectors reviewed the records of these meetings which

evidenced that while the young people were able to raise issues, the records were predominantly a record of staff informing young people about their day to day plans. The inspector advices that the centre manager reviews the process for house meetings to ensure that it reflects issues that the young people might have and that the process includes feedback given to the young people regarding issues raised by them.

One of the young people was due to move on from the centre in the coming months. Account was taken of the views of the young person regarding the transition plan and of their move from the centre. A review of the key work reports evidenced that the young person was involved and consulted about all aspects of their care. There was further evidence in key work reports that the staff acted as good advocates for the young person in preparing them for attending professional meetings about their care plan. The young person told the inspector that they felt involved in the decisions of their care plan. That they attended their care review meetings and that account was taken of their views. There was further evidence of meetings with the social worker and other professionals in the planning of the young person's transition from the centre.

The second young person told the inspector that they were consulted about the daily life of the centre regarding food, choice of clothes and activities

The young people were given information about EPIC (Empowering People In Care), which is a national agency that advocated for young people in care. The centre manager confirmed that EPIC attended the centre to meet with the young people.

3.4.2 Practices that met the required standard in some respect only

Complaints

The centre had a policy and procedure in place to manage complaints. Information booklets given to young people were clear regarding the process for complaints. The young people told the inspector that they knew how to make a complaint. The findings of the inspector were that there were two systems in place for the recording of complaints. The centres policies and procedures state the following, 'informal complaints should be recorded as 'informal complaints' in the complaints register, and cross referenced in the daily log and brought to the attention of the centre manager'. However, the practice within the centre was that informal complaints were not recorded on the centre complaints register. The stated reason for this through interview with staff was that staff dealt with issues of complaints in the

immediate. Staff felt that they had a good relationship with the young people and that if they were unhappy with something that they could deal with it there and then. This was contrary to the stated policies and procedures for the centre. There was no record of informal complaints on file. The centre manager must ensure that staff adheres to the centres policies and procedures regarding complaints. The centre must provide further information to young people of the most recent national complaints policy utilised by TUSLA – Tell Us.

The centre manager held a formal complaints register. Three formal complaints were made by a young person. The centre log evidenced that there was one complaint recorded on the centres register log dated the 18th November 2017. The centre manager informed the inspector that the complaint was the subject of an internal investigation by the service which had not yet reached an outcome.

The centre manager made the inspector aware of two further complaints. These complaints were made by the same young person between the 8th of January and the 22nd of January 2018. Both complaints necessitated an internal investigation by the service. There was evidence on the file to show that the issue had been investigated and an outcome reached as to the complaint. There was evidence to show that the young person was consulted about the complaint and was given feedback by the centre manager regarding the complaint. Both complaints were then recorded on the centre register.

The operations manager had oversight of the complaints process however, they had not identified that the centre was not in compliance with its policy on complaints. They must ensure that the centre maintains one register of complaints to include both informal and formal complaints. All issues raised by the young people should be recorded to ensure that they are dealt with and that the young person is satisfied with the outcome of the complaint.

There was a record to show that the placing social worker had been notified of complaints through the significant events process. There was no record that the placing social worker had satisfied themselves as to the outcome of the complaints. This issue was addressed directly by the inspector with the placing social worker. The placing social worker must satisfy themselves that they are satisfied with the outcome of the complaints.

3.4.3 Practices that did not meet the required standard

None identified.

3.4.4 Regulation Based Requirements

The Child and Family Agency had met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995, Part II, Article 4, Consultation with Young People.***

Required Action

- The centre manager must review the process for house meetings to ensure that it reflects issues that the young people might have and that the process includes feedback given to the young people regarding issues raised.

- The centre manager must provide further information to young people of the most recent national complaints policy utilised by TUSLA – Tell Us.

- The centre manager must ensure that staff adhere to the centres policies and procedures regarding complaints.

- The operations manager must ensure that the centre is in compliance with its policy on the management of complaints.

- The placing social worker and the Child and Family Agency, TUSLA must satisfy themselves that they are satisfied with the outcome of the complaints.

3.6 Care of Young People

Standard

Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

3.6.1 Practices that met the required standard in full

Managing behaviour

There were written guidelines for staff on how to respond to inappropriate behaviour. Training is provided to full time staff with an approved model of behaviour management where the emphasis is placed on addressing behaviours that challenge in a therapeutic way. Individual crisis management plans (ICMP) were in place for the young people and were updated on a regular basis. The inspectors found that where the young people had exhibited behaviours that challenged that the strategies used to intervene and manage behaviour were reviewed by the centre manager.

There was good engagement with other services in supporting the young people through Community Subsistence Misuse Programme, Garda Diversion Programmes, Probation and Welfare Services. The centre had to at times to rely on the assistance of the Gardai to support staff in the management of the young people's behaviour. The clinical team within the service is available to do individual work with the young people.

The findings of the inspector were that the centre demonstrated a resilient approach to managing challenging behaviour within their admission procedures. Staff made great efforts to engage and build relationships with the young people. It is the view of the inspector that if the service had a clear outline of the programme of care that they envisaged for the young people it would support and enhance staff practice.

Restraint

The centre utilised a recognised model of physical restraint. Restraint was viewed by the team as a final intervention in a very serious incident. The centre held a register of all restraints. There was evidence in the significant event reports to show that the restraints were review by the centre and external management and that where necessary feedback was given to staff.

3.6.2 Practices that met the required standard in some respect only

None identified.

3.6.3 Practices that did not meet the required standard

None identified.

3.6.4 Regulation Based Requirements

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

-Part III, Article 11, Religion
-Part III, Article 12, Provision of Food
-Part III, Article 16, Notifications of Physical Restraint as Significant Event.

3.7 Safeguarding and Child Protection

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.

3.7.1 Practices that met the required standard
None identified.

3.7.2 Practices that met the required standard in some respect only

The inspector found that the centre has a written policy on safeguarding young people in the centre. It has in place a child safeguarding statement in line with the Children First Act 2015. All staff working at the centre had the required Garda vetting and were in receipt of formal induction to the centre. All staff were provided with regular and formal supervision. All staff had recently completed the on line E-Learning programme provided by the Child and Family Agency TUSLA in Children First Training. The services were currently reviewing the delivery of its Children First training programme in light of the Children First Act 2015.

Staff understood their role in safeguarding children they were clear of their role in the reporting concerns about a child. However, not all staff were clear as to who the designated liaison person was for the centre. The centre had a complaints procedure in place for dealing with complaints made by young people; however, it was not adhering to its stated policy in the recording of informal complaints made by young people. There were guidelines in place for responding to any allegations or complaints about staff at the centre.

The rights of the young people were fostered within the life of the centre through the use of positive relationships with the adults. The young people had regular phone contact with their social workers. Young people were central in the process of team discussion. The centre manager completed pre-admission risk assessment and impact risk assessment prior to admission. A needs assessment is completed within

eight weeks which identify placement plans and subsequent risk. The centre maintains a register of significant events including any child protection and welfare concerns. The team were provided with access to a clinical team attached to the service. There was good inter-agency involvement with the young people.

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 clinical manager was the designated person for the reporting of child protection and welfare concerns. The operations manager was the designated person with oversight of complaints. Two formal complaints with associated child protection concerns had been made by one of the young people in January 2018. Both complaints were assessed and deemed to require the submission of Standard Report Forms. Following a request from the placing social worker Standard Report Forms were retrospectively submitted in March 2018. The reports were not submitted in a timely manner as required in line with Children First procedures. The stated reason for the delay was to seek clarification from the social work department as to whether or not the issue required a child protection notification.

A third standard report in respect of the same young person was submitted to the social work department on the 22nd of November 2017. This was following a significant event dated the 18th of November 2017. The social work department must acknowledge receipt of all standard report forms and satisfy itself as to the outcome of the reports.

The service must review the role of the designated liaison officer and the role of the operations manager with reference to the management of complaints and in the reporting of child protection concerns. There needs to be a clear distinction between complaints and child protection concerns. All complaints and significant event reports must be screened to ensure that child protection concerns are appropriately reported and managed under Children First.

3.7.3 Practices that did not meet the required standard

None identified.

Required Action

- The service must review the role of the designated liaison officer with reference to the management of the reporting of child protection concerns.
- The centre manager must ensure that all staff are clear of who the designated liaison officer is within the centre.
- The placing social worker must acknowledge receipt of child protection report forms submitted to the social work department. They must satisfy themselves as to the outcome reports.

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

Accommodation

The inspector was satisfied that the accommodation was fit for purpose. The centre was adequately lit, heated and ventilated and there were suitable facilities for cooking and laundry. There was adequate space within the centre for the young people to have visits from other professionals and their social workers in private. The young people have their own bedrooms. However, due to behaviours that challenged by one of the residents the centre was subjected to property damage. The centre manager was in the process of assessing the damage and setting out a schedule of repair work.

The centre had a written health and safety policy statement signed by the chief executive officer.

The centre manager provided evidence that the centre was adequately insured. The insurance schedule was dated up to the 31st of December 2018.

Maintenance and repairs

The centre manager reported that general maintenance requirement was carried out routinely and addressed promptly by the service. The findings of the inspector were that the overall state of the building was in good repair. The centre manager had identified some issues of repair that required attention. A maintenance schedule was in place to address issues in a timely fashion.

Fire Safety

The centre relocated premises in October 2017, documentation on file in respect of fire safety was reflected from that date. The centre manager was the designated person with responsibility for fire safety within the centre. The building had an appropriate fire detection and central alarm system. Records evidenced that the fire panel was installed on the 31st of October 2017. A copy of the fire detection and alarm system certificate of installation was on file.

Emergency lighting and a smoke detection system were in place throughout the building as were sight specific evacuation plans. A copy of emergency lighting system certificate of commissioning was on file dated the 31st of October 2017.

A copy of the inspection report of the premises by a Chartered Engineer dated the 27th of October 2017 was on file which stated that the centre was in compliance with fire regulations.

The building had the required fire extinguishers and fire blanket and all firefighting equipment. However, the fire extinguishers had to be removed from their designated fire points throughout the building. This was done as a safety measure due to behaviours that challenged by one resident. The removal of the fire extinguisher had been risk assessed by the centre manager. The location of the fire extinguishers was recorded in the team handover sheet and was relayed verbally to staff in the course of shift handovers.

There was evidence that daily visual inspection of the central alarm system were undertaken by care staff. Staff were also undertaking a daily visual inspection of the means of escape from the centre. Fire prevention and evacuation procedures were being carried out by the team.

The centres policies and procedures outlined procedures for staff to follow in the event of a fire occurring. The statement must be signed as having been read by all staff. All of the core staff were trained in fire safety. Three relief staff did not have fire safety training.

3.10.2 Practices that met the required standard in some respect only

Safety

The inspectors found that the centre had a Health and Safety procedure document. On review of the document the findings of the inspector was that it was not specific to the centre. It was last signed as having been ready by a member of staff on the 2nd of November 2011. The procedure document must be reviewed and updated with reference to the centre. When updated it must be read and signed by all staff.

Training in first aid was provided to all members of the core team. Four members of the relief team required training in first aid. The centre had a safe facility for secure medication. The first aid kit held all of the appropriate supplies and was monitored on a regular basis to ensure that it was kept in stock.

The centre had two vehicles to transport the young people. A copy of staff driving licences were held on the personnel files. The inspectors reviewed staff insurance certificates and road tax certificate. Both cars were legally insured and were properly licensed.

3.10.3 Practices that did not meet the required standard

None identified.

3.10.4 Regulation Based Requirements

The centre had met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996,***
-Part III, Article 8, Accommodation
-Part III, Article 9, Access Arrangements (Privacy)
-Part III, Article 15, Insurance
-Part III, Article 14, Safety Precautions (Compliance with Health and Safety)
-Part III, Article 13, Fire Precautions.

Required Action

- The management team must ensure that the health and safety procedure document is specific to the centre. It must be signed as having been read by all staff.

4. Action Plan

Standard	Issues Requiring Action	Response with time scales	Corrective and Preventative Strategies To Ensure Issues Do Not Arise Again
3.1	The chief executive officer must ensure that the information provided in its statement accurately describe the specific care approach used by the centre. Staff must be familiar with the care programme of the centre.	The needs assessment model of care is used in Fresh Start. Following the review of our clinical services there will be a revision to the MDT meetings. All young people will have a needs assessment completed within 8 weeks of admission by their key worker (see attached template) and a general psychological assessment completed by a psychologist.	The clinical manager is due to meet with the quality assurance and practice manager to review the supervision format and documentation and will ensure this model of care is reflected in this. We have then arranged an information session with all managers and deputies at the July managers meeting so that the model of care and supporting documentation can be cascaded down to teams. Additionally we will look at this as and when new policies are annually reviewed.
3.2	The operations manager must review how supervision is recorded to ensure that the records accurately record the process of supervision. The operations manager must ensure that relief staff receive the required training in	The Quality Assurance & Practice Manager has taken responsibility for reviewing how supervision is recorded. All new staff attend development training when they commence employment. Shadow	The Quality Assurance & Practice Manager will conduct monthly monitoring visits to the centre and Supervision records will form part of this monitoring. Fresh Start provides training to all staff to meet the needs of young people in line with

	first aid, fire safety, first aid and staff must be trained in behaviour management before working in the centre.	shifts are completed and mandatory training needs are determined at this point. Should a staff member not be trained in TCI there will be a clear risk assessment outlining this and it will be detailed in the young person's ICMP.	the National Standards. Prior to commencement of work all staff attend an induction day and complete shadow shifts to familiarise themselves with the centre, young people, placement plans, routines ICMPs and Policies and Procedures. They also complete the new Children First E-Learning Programme. Within the first three months they should attend a new staff development course which includes manual handling and TCI. Fire safety and first aid is provided for all staff. Training identified specific to centres is also provided as required.
	The chief executive officer must ensure that the program of care being delivered at the centre is clear to both management and staff.	The organisation sets out it program of care in its mission statement which states "the young people's individual needs may require that we provide innovative and radical services. These will be provided on an informed, planned and well-considered basis." It is important that the care approach is tailored towards the young person rather than the young person being tailored towards one specific care approach for the centre.	The programme of care will be reviewed by the Clinical Team prior to the admission of new referrals.

	The operations manager must ensure that staff are provided with training in the care approached used by the centre.	The Clinical Team will provide the necessary training prior to the admission of all new referrals.	The programme of care will be reviewed by the Clinical Team prior to the admission of new referrals and training needs of the care team will be identified and delivered prior to the admission of the young person.
3.4	The centre manager must review the process for house meetings to ensure that it reflects issues that the young people might have and that the process includes feedback given to the young people regarding issues raised.	The House Manager has reviewed the House meetings with the care team at a team meeting on the 18-03-18. A house meeting will be held with the young person prior to the Team Meeting to address any issues or topics of interest to them. These issues will then be brought to the team meeting and a member/s of the care team will be identified to provide feedback to the young person following the Team Meeting. This feedback will be recorded in the House Meeting Book.	This process and its effectiveness will be reviewed every quarter at a Team Meeting by the House Manager, Deputy House Manager and Social Care Team.
	The centre manager must provide further information to young people of the most recent national complaints policy utilised by TUSLA – Tell Us.	The current young people in the centre have been informed about "Tell Us" through one of their House Meetings. A poster relating to the subject is now in the communal area of the centre.	All new young people admitted to the centre will be informed about "Tell Us" and the information relating to it will form part of their welcome pack to the House.

	The centre manager must ensure that staff adhere to the centres policies and procedures regarding complaints. The operations manager must ensure that the centre is in compliance with its policy on the management of complaints.	A Team Meeting has been scheduled for April 2018 and part of the agenda for this Team Meeting is to address the Complaints Policy and ensure all staff are informed and up-to-date on this policy and their roles and responsibilities. The Operations Manager will attend the Team Meeting in April 2018 to highlight this recommendation and to ensure the care team are aware of their responsibilities.	All new staff starting in the centre will be provided with the relevant policies and procedures on complaints and the complaints policy will be reviewed quarterly at Team Meetings within the centre. The Operations Manager will regularly review the centres compliance with the management of complaints.
3.7	The service must review the role of the designated liaison officer with reference to the management of the reporting of child protection concerns. The centre manager must ensure that all staff are clear of who the designated liaison officer is within the centre. The placing social worker must acknowledge receipt of child protection report forms submitted to the social work department. They must satisfy themselves	The CEO is clear about the role of the Designated Liaison Officer relating to Child Protection Concerns and this has been addressed with the care team in a Team Meeting on the 18-03-18. This was reviewed in a team meeting on the 18-03-18 with the care team and a visible notice relating to the Designated Liaison Person has been placed in the staff office. Social Worker	The role of the Designated Liaison Officer relating to Child Protection Concerns will be further highlighted in the staff induction and staff development programme. The role of the Designated Liaison Person will be reviewed every quarter at the Team Meeting. Social Worker

	as to the outcome reports.		
3.10	The management team must ensure that the health and safety procedure document is specific to the centre. It must be signed as having been read by all staff.	The organisations Health and Safety Consultant visited the centre in November 2017. His report was furnished to the House Manager on the 17-04-18.	An organisational system has been put in place to ensure this does not reoccur and that all Health and Safety documents are forwarded to the centres in a timely manner.