An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 090

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Cottage Homes**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**22nd 23rd and 28th of August 2023**
Registration Status:	**Registered with conditions attached from the 17th of October 2023 to the 17th of October 2026**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**2nd November 2023**

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 and Regulation 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 in August 2000. At the time of this inspection the centre was in its eighth registration and was in year three of the cycle. The centre was registered with an attached condition from the 17th October 2020 to the 17th October 2023.

The centre aimed to provide medium to long term care for four young people from age thirteen to eighteen years of age. The model of care was a relationship-based approach with the provision of a safe, secure and supportive environment to encourage the holistic development of each young person. 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
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.1

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.

The inspector's core task during this inspection was to review the conditions attached to the registration of the centre since May of 2023, that being no new admissions permitted. An assessment of the implementation of the corrective and preventative action plan, CAPA, accepted by the ACIMS registration panel was completed to inform this process.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 26th of September 2023 and to the relevant social work departments on the 26th of September 2023. 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 6th of October 2023. This was deemed to be require some further explanatory detail and the inspection service requested evidence of the issues addressed. An updated CAPA was received from the centre manager on the 12th of October 2023. A meeting took place between the ACIMS Regional Manager and the Service Director on the 20th of October 2023 to discuss the CAPA implementation.

The findings of this report and assessment of the submitted CAPA deem the centre to be making significant progress in implementing the improvement plan, however the centre will need time to fully comply with and come into adherence with all 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: 090 with an attached conditions from the 17th of October 2023 to the 17th October 2026 pursuant to Part VIII, Article 61(6)(a)1991 Child Care Act.
The condition being:
The centre must fully implement all the actions identified in the preventative and corrective action as submitted by their service on the 12th of October 2023. The attached condition will be reviewed by the 31st of March 2024.

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.

This centre was based in housing estate in a large suburban area and was adjacent to many services. The property was well presented and there was evidence of investment in its upkeep. There were new carpets, freshly painted walls and soft furnishings were looking well presented and homely. There were plenty of games and activities to do together evident in the house, including an additional make up room upstairs. This is a large property with ample space for privacy with family and friends on the ground floor. The house was clean and generally well maintained on the day of the inspection. The garden contained fruits grown by the team and used by a young person, there was seating and a barbecue area and new exterior lighting had been added at the back and front of the house. The staff office had been upgraded and a new garden room added.

Inspectors found that the upstairs of the property which has an older layout of bathrooms and bedroom sizes should be reviewed in due course taking account of the centres capacity, approaches to care and the privacy needs of young people. A social worker informed inspectors that the layout of the bedrooms was presenting some privacy concerns for their young person, inspectors advised that this be made known to the centre so that they could ensure the comfort of the young people. There was a new garden room at the centre which was described as being for staff use for supervisions sessions and other meetings as well as a downstairs toilet locked for staff use. The inspectors have requested that the locking and designating of separate staff facilities that are not office and bedroom areas be ceased as it detracts from a homelike environment.

There was a dedicated health and safety representative on the team, they met as part of a health and safety committee on a quarterly basis. The committee comprised the

centre managers, the director and the health and safety representatives. There were monthly centre health and safety walkthroughs and six monthly director property reviews. The health and safety committee records evidenced actions and decisions with follow up. The monthly centre walkthrough records did not evidence ongoing monitoring and actions, for example items that arose related to mould or significant hygiene issues in a bedroom could not be followed by inspectors to see how they were successfully tackled or reduced. Overall inspectors found that maintenance records and the car log lacked detail and required that closer attention be paid to dates, completions and noting changes.

There was evidence of auditing of compliance with safe systems such as medications management and actions identified from these by the director. There had been upgrading of fire doors and sensors with a new alarm panel added to assist with centre safety. There were updated fire points added also. Inspectors asked the management to keep in mind revision works also to include removal of older fire alarm systems in the bedrooms like bell sounders. There were bedroom door alarms and a stair sensor that were utilised on a risk assessed basis to support safe care, these were reviewed through the restrictive practice procedures.

Inspectors found that there was insufficient evidence of fire drills being completed, a young person informed inspectors that they had taken part in one after they moved in the previous year but none since. Staff named that they had been inducted into the fire system, evacuation plan and assembly point. Inspectors could see records of fire checks, fire inductions, some training and bell tests but not drills. The maintaining of good quality fire records was an issue identified for action in 2020 inspection which inspectors have found has not been actioned fully.

There was a safety statement in place and a health and safety company contracted to support this. There was a system for recording accidents and there was insurance in place in line with the relevant regulations. There were risk assessments in place for all aspects of health and safety. There was a new electric vehicle and car charging point installed. There were records kept of regular car checks and some of the detail on these required attention as well as noting when vehicles change and how many there are in service.

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	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 2.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The director and the centre management team must ensure that in the governance and oversight of health and safety and fire systems, including fire drills, that the necessary systems and polices are followed, recorded and overseen at the centre.

Regulation 5: Care Practices and Operational Policies
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 was last inspected in January 2023 by the ACIMS risk response team who found significant issues of concern in safeguarding, finding that the centre did not effectively safeguard specific young people in their care. Since that time two young people had moved from the centre, in February '23 one of the young people who was most at risk was the subject of an unplanned discharge and a second young person returned home successfully in the Summer.

Inspectors established that staff required training in their safeguarding policies and procedures, for some it would be their first training as new staff and for others their two year renewal was falling due in the coming weeks. The director had identified

the month of September for completing this. The centres policy also stated that there would be two yearly renewal routines for the national Children First eLearning module, this renewal time frame must be added to the centres training excel record. There was some confusion as to whether new staff joining the organisation could provide their existing Children First eLearn certificate or if it was required to be redone as part of the induction process. This must be clarified and the training records on file must reflect that if older certificates are not the standard accepted. The training excel must be updated to include who had received designated liaison officer (DLP) training.

The safeguarding policy was well developed in line with the relevant guidelines and legislation, it had been reviewed in 2023. Child sexual exploitation was recognised within it under the category of Sexual Abuse. Inspectors noted that a procedure for non-mandated persons should be added to the policy in due course. Inspectors also recommended that all staff access the mandated persons briefing available online through the Tusla website.

The child safeguarding statement was in place, updated and displayed in the office. Inspectors found that there was some knowledge displayed by staff of the risks listed within it but that the team must continue to identify learning opportunities related to child safeguarding and the tools the team have access to.

One of the key requirements of the corrective and preventative action plan (CAPA) submitted following the January 2023 inspection was a need to improve practices in risk and safety planning. Inspectors found that there had been development in planning and review of safety plans and risk assessments. Training had been delivered to the team in compliance with the commitments made in the CAPA. There was evidence of risk review and discussion at team level and at senior management level. There was a young person's risk register in place which supported the tracking of same.

Inspectors found that more awareness and development was required on an ongoing basis to support the safe care of children who may be or have been at risk of abuse or exploitation. There was evidence of uncertainty when new situations arose regarding what actions staff should follow or indeed when it was appropriate to be concerned and take action. It was noted for example that the relevant antecedents were not contained within a missing from care episode that merited inclusion. These were elsewhere on the record and had been discussed with the DLP but the record of that was incomplete and the matters were not kept in view when developing ongoing safeguarding for the young person involved.

Inspectors found that development was required in including young people more in that safety planning, some improvements had taken place such as developing safe words and changing sim cards in conjunction with a young person. There was not enough evidence recorded of key work and direct work related on living safely so the young people's voice was somewhat lost across the documents as currently structured. One young person that the inspectors spoke with stated that they felt safe and happy that the staff listened to what they needed and wanted. Two social workers stated that their young person had settled into the centre well.

There were daily log entries and records of concerns that were deemed by the DLP to have fallen under the threshold for reporting as child protection concerns that highlighted gaps still existed in practice. Where the centre manager as DLP met with a staff to consult about concerns to discuss thresholding the records were poorly laid out and did not meet the expected standard for same as set out in their policy. The records lacked key elements such as the persons involved, whether a social worker was aware or a parent and by who and how would follow up be done with a child regarding the matters noted. In the instances involved these included going to meet persons unknown, outside the centre, that staff had no knowledge regarding. When inspectors queried about a second event from a daily log of a similar nature the centre manager described a different expectation of practice than that which was followed by the staff in their absence.

There was a child protection reporting register in place that would benefit from some additional key details regarding closure of entries, for example closed by whom and on what date. The relevant social worker explained that they were asked for information and updates regarding open child protection matters and were responding to those. They had also followed up within their social work department management regarding reports open from prior to them taking over the case. Evidence of the regular updates were not always attached to the child protection reports on file and these required tidying and refiling. The social worker was satisfied that they saw evidence of work on self esteem and wellbeing and was positive about the role of the key worker and the centre in terms of improvements in the young person's safety.

Both young people had risk assessments, individual crisis management plans and behaviour management plans on file. With this being a newer team, the plans would benefit being more explicit in relevant areas and capture how the work would be done in supporting the young people. It was noted that the crisis management format should have been changed and had not been, the edition of the training staff had completed in early 2023 included a new format for crisis support planning which had not been introduced at the centre. The monthly progress reports captured more of

the direct work and a sense of a relationship based approach but inspectors found that this needed to be built on through more focused and consistent key work and better daily routines that show robust engagement with young people that ties the areas of their needs, wants and any risk together more. The director had identified this as an area for investment and had already contracted a consultant to commence placement planning work with the team from the Autumn of 2023.

In reviewing how vulnerable children would be protected from ongoing exposure to potential harm inspectors did not get a clear message from the records and staff of young people being vigilantly monitored for signs of vulnerability. The team need to be led in remaining constantly curious in their own analysis of situations regarding safety and age appropriateness. The records of direct work, connected to areas of vulnerability and personnel safety, were difficult to track, often short engagements but some were purposeful and better represented in monthly progress reports. Where the good practices were evident like collaboration with another centre on peer to peer safety, supporting and including a parent and working on self esteem and phone safety these had not been extracted and highlighted for learning and emphasised as examples to be built upon. The team meeting records did not note this but in samples of supervision provided it was evidenced where good practices were discussed and promoted.

The weekly plans, daily diaries and placement plans did not represent the evidence of the work being undertaken to engage the young people related to their individual areas of vulnerability. Social workers and other professionals have noted improvements in the young people and also gaps in initiative such as need for more expansive and ambitious daily/weekly plans. The daily diary entries for the young people consistently referred to getting up late and/or spending the day in their room. At weekly team meetings the minutes did not capture this aspect and examine it for safeguarding, mental health or hygiene aspects.

There were records of consulting with young people through young people meetings, an area where again entries were scant and did not contain good evidence of staff going back to young people about anything they may have raised. Team meetings were held weekly and the minutes were not capturing the actions identified to address issues noted or brought for discussion at it. Where significant events were discussed the minutes again were unclear regarding any changes to practice. Feedback from director audits was recorded as included at the team meetings also.

Overall inspectors found that a range of actions had been implemented from the 2023 CAPA and some improvements had been generated. There remained reason for caution based on some of the evidence to find that in the area of safeguarding there must continue to be improvements in following policy, implementing good

safeguarding and the registered proprietor and management team must ensure that these remain priority practice development areas.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management team must update the excel record to include all renewal dates, all persons DLP trained and the child safeguarding training must be confirmed as scheduled or completed for the team. The staff team must complete the mandated persons briefing on the Tusla website.
- The centre management must ensure that they clarify the expectation of Children eLearn renewal at induction for all staff.
- The director of services and the centre management must ensure that they strengthen and continue building on good safeguarding procedures through including learning opportunities from practice at the centre and gaps identified. This must remain a priority practice area.
- The centre management and the staff team must review the approach to engagement with young people and how they capture their voice and inclusion in their care.
- The centre manager as DLP must improve the records of consultation regarding concerns that they found did not meet the threshold for reporting in line with the expected standard for same as set out in their safeguarding policy.
- The centre management and staff must ensure that there are detailed plans in place for the young people that support their needs and build on good daily routines.

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

Theme 5: Leadership, Governance and Management

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

The director of services had completed audits of this centre in the period since the last ACIMS risk response inspection undertaken in January 2023. Copies of two quarterly audits and a copy of the annual audit of compliance were provided to inspectors for review. Inspectors did not see an explicit and clear tracking of the implementation of the CAPA that was submitted in response to the last inspection. Therefore, when an item was left behind like a critical incident format it was not easy for the management team to note that. Other improvements had also been identified from audits and internal review by the management team, for example in May 2023 improvements were identified for the significant event review process, this was to include learning logs to improve the flow of learning through the organisation. These were also pending implementation.

Once a range of documents and meeting records had been reviewed inspectors tracked each action and the response provided by the centre through the various governance systems. There was no bench marking by the centre of where they had progressed to and although changes had taken place an assessment of the impact and fit of these was not evident. Inspectors found that though much had been achieved that there must be ongoing tracking to satisfy themselves, the board and Tusla that they will retain the improvements made at this time. The preceding three years of inspections had each involved regulatory and/or standards compliance issues that had recurred thematically.

The director had in place quarterly auditing with an action plan template improved further since July 2023, there were monthly managers meetings, governance reports from the centre managers and monthly board of management meetings. The director had a structured two yearly or as needed policy review process established and there was evidence of improvements upcoming through investment in a new placement planning approach to replace their existing system. The director had delivered internal training in the risk management framework and in the safeguarding policy and procedures suite with the latter due again for newer staff.

Inspectors found that in the general business of the managers meetings that actions were assigned and persons named. There were risk registers in place and these were reviewed in accordance with the policy. There was awareness demonstrated by the staff of their administrative role in risk management regarding completing risk assessments. Inspectors found that the staff still needed to focus on better recording of details to inform good safeguarding and risk management. The integration of learning from the director governance level to the team was found to require ongoing improvement as feedback from managers meetings, audits, significant event reviews and general discussions and decisions were not being captured on team meeting minutes.

The voluntary body board member who spoke with inspectors stated that the board were happy with the direction of the service and the performance of the team and the centre. They confirmed that they were updated monthly through a governance report provided in advance of the meeting and had opportunities to ask questions that they found to be answered fully by the director of services.

The inspectors found that the directors had completed a comprehensive annual review of compliance. This was a good process with actions identified within it that were then brought to the team meeting. The overall document would benefit from additions regarding who completed the report and the views of the young people could be better represented in a manner that would represent the works undertaken at the centre to promote improvements towards better outcomes for children.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The director of services must continue to refine the flow of learning and seek evidence from the centre that this has taken place.

- The director of services and the centre management must satisfy themselves that the CAPAs from this registration cycle have been duly completed and assess the actions undertaken regarding impact for young people. The learning from this must be taken account of when offering future placements for young people.

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.

This centre had a condition attached to their registration in May of 2023 due to not having sufficient numbers of staff and inadequate practices related to safeguarding. During this inspection compliance with the relevant regulation Childcare (Standards in Childrens Residential Centres) Regulations 1996, Article 7, Staffing was reviewed. Inspectors were provided with an updated staffing list that included a social care manager, a deputy social care manager, two social care leaders and six social care workers. The director and centre manager had completed a successful recruitment process resulting in filling the vacant posts on the team and also recruited additional relief staff also to strengthen the wider resources. This recruitment process now brings the centre into compliance with the minimum numbers of staff required.

Inspectors reviewed a sample of four personnel files and found these to be well maintained and in line with safe recruitment practices and the centres recruitment policy. There was evidence of planned audit by centre management of the personnel files. There was evidence of workforce planning being discussed on an ongoing basis by the director and the centre management team.

Part of the centres response to the January 2023 risk response inspection was a focus on maintaining clear and accurate roster records. Inspectors reviewed a number of rosters with the deputy manager who holds responsibility for them. The rosters identified where shifts were filled by relief staff or agency workers, there was still some limited use of occasional agency staff up to July 2023 but this has now been discontinued with the availability of sufficient numbers of relief staff. A total of five of a wider number of relief staff were confirmed as fully available to the centre, the others were less available or covering a post at the sister centre. There was regular

use of recurring relief staff names to cover annual leave during the summer months. The rosters also contained a record of the on-call persons and numbers at the front of the hard copy document and was available in the staff office.

The full time staff team were qualified and contained a mix of experienced and less experienced staff. During the inspection process inspectors found that the matter of clarity of roles and responsibilities remained an area that required ongoing attention. The addition of a full time deputy manager Monday to Friday had brought some clarity to the division of roles. The roles, responsibilities and tasks of the social care leaders were not clear and not fully evidenced throughout the records at the centre. There were aspects of daily and other records that had not been followed up on by staff, some were of smaller impact such as filing whilst others had the potential to be more consequential like being alert to what information merited action related to young people safety or identifying where a plan type should be updated for example moving from the ICMP to the ICSP after the updated training had been completed. This issue had been raised in several inspections in the cycle and remains an area requiring attention now.

The lack of additional budget for on call services remained an ongoing discussion area between the voluntary body and the Tusla during their service level agreement meetings. The centre and the director had taken action to improve the on call response options following the January 2023 findings that they were inadequate. There was evidence of meetings with the staff team and review of on call following the last inspection with the revised system rolled out to all staff.

The voluntary body acted to provide what additional benefits and supports they could to enhance staff retention including recognition of the values and ethos of the service, the working conditions and one off benefits agreed by the board. The two staff who met with inspectors and the one young person named that it was a nice place to work and live. Social workers stated that the staff team were good to deal with and responsive to the young people.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The roles and responsibilities of staff must be addressed through centre training, supervision and development processes at the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The director and the centre management team must ensure that in the governance and oversight of health and safety and fire systems, including fire drills, that the necessary systems and polices are followed, recorded and overseen at the centre.	With immediate effect the Centre Manager with the Health and Safety representative will do a robust review of the current Health & Safety and fire systems and processes in place with a focus on scheduling and tracking. This will include the car log, maintenance log and hazard book. Learning from the monthly Health and Safety walkthrough will be brought to the team meetings. Since the inspection until time of writing 3 Fire Drills have taken place including a night time Fire Drill. The current systems in place will be reviewed with the team at the team meeting on the 10/10/23 to ensure the process is understood.	This will be reviewed by the Director of Service, Centre Manager and by the Health & Safety representative in their individual periodic review. The annual plan for the Heath and Safety schedule, including fire drills will be preplanned for the upcoming year in January and logged in the general diary. On a monthly basis the health and safety rep will review the fire drill records to ensure that drill are taking place.

3	The centre management team must update the excel record to include all renewal dates, all persons DLP trained and the child safeguarding training must be confirmed as scheduled or completed for the team. The staff team must complete the mandated persons briefing on the Tusla website. The centre management must ensure that they clarify the expectation of Children eLearn renewal at induction for all staff.	The excel records has been updated to include renewal dates for any trainings that require renewal. The two SCL's who require DLP training are booked onto training on the 4/11/23. All staff will complete training on the organisations Safeguarding policy and procedure in November 2023. The organisation's policy has been updated to reflect that Children's First E-learning training should be completed every 3 years in line with Tusla guidelines. All staff will complete the Mandated persons briefing by 31/10/23. All staff will complete Children's First e-learning at induction and renew every 3 years thereafter. The Safeguarding Policy has been updated to reflect same. A procedure for non-mandated persons to follow has been added to the Safeguarding Policy.	The Deputy Manager will review the training excel on a monthly basis to ensure records are up to date. The Manager will then be provided with a copy of this excel. This will also be reviewed by the Director of Service as part of the quarterly audit process. The policy has been amended to clarify this issue. All Policies are reviewed by the staff, Centre Manager and Director as part of Policy Review Schedule.

	The director of services and the centre management must ensure that they strengthen and continue building on good safeguarding procedures through including learning opportunities from practice at the centre and gaps identified. This must remain a priority practice area.	The paperwork from the example used in the inspection report was reviewed at the team meeting on 5/9/23 and gaps in recording and practice were highlighted to the team for learning and this will inform future practice. Safety plans are reviewed in real time and are brought to daily handovers and team meeting on a weekly basis for review. All staff have completed E-Learning in Child Sexual Exploitation. Learning opportunities and gaps in practice will be addressed in handovers, supervision and team meetings. This will form part of the discussions at the team facilitation session is booked for the 17th of October and we are arranging Safeguarding training in November 2023 and will be starting the process of introducing the Well tree Model of Care in the coming months.	This will continue to be a priority and will be reviewed regularly through Managers meeting and Director audits.
	The centre management and the staff team must review the approach to engagement with young people and how they capture their voice and	An internal review will be conducted by centre management by November 2023. Director of service will meet with the young people (during October midterm at	This will be reviewed as part of the key worker 5-week case review to ensure that the young person's voice is being captured. The manager will review this as part of

	inclusion in their care.	the latest) and will consult with them how they would like to be included in their care. More detail will be included in young people's meeting minutes and feedback from these will be clearly recorded in Team Meeting Minutes and responses fed back to the young person and recorded on their file.	their monthly audit. The Director of Service will review this as part of their quarterly audit process.
	The centre manager as DLP must improve the records of consultation regarding concerns that they found did not meet the threshold for reporting in line with the expected standard for same as set out in their safeguarding policy.	A central log has been created for concerns that do not meet the threshold for reporting which now includes all relevant information as outlined in our Safeguarding Policy. This was enacted on the 3rd of October 2023.	The new log will be included in Centre Manager's audits and trends will be highlighted at team meetings. These will also be reviewed as part of Managers Meetings and in the Director of Services quarterly audit process.
	The centre management and staff must ensure that there are detailed plans in place for the young people that support their needs and build on good daily routines.	Centre management are in the process of reviewing our current weekly planner with a view to enhancing its use across the service. This will be done in consultation with the young people, our other residential service (at a joint team meeting	The weekly plans will be reviewed as part of the five-week case review. The manager will review this as part of their monthly audit. The Director of Service will review this as part of their quarterly audit process.

		on the 7/11/23) and Tusla CRS DML. Once enacted these plans will be agreed with the young person at the start of the week and brought to team meetings and recorded in the young persons file and any relevant appointments will be logged in the General diary as per current system.	
5	The director of services must continue to refine the flow of learning and seek evidence from the centre that this has taken place. The director of services and the centre management must satisfy themselves that the CAPA has been duly completed and assess the actions undertaken regarding impact for young people. The learning from this must be taken account of when offering future placements for young people.	In addition to conducting quarterly audits and requesting responses from the Centre Manager, the Director of Service will review previous audits and other relevant documentation to ensure that learning has taken place. A CAPA review form has been created and implemented which tracks outcomes and evidence work completed. We will be carefully considering any future placement with the learning from past CAPAs through Collective Risk assessment.	This will be reviewed as part of the Director's auditing process for evidence on a quarterly basis and through team meetings. The new CAPA review form will be reviewed by the Director of Service and centre management as part of the new CAPA review process to ensure the work has been completed. This will also be reviewed through team meeting very ten weeks with the team.
6	The roles and responsibilities of staff must be addressed through centre	As part of addressing this staff will review their job descriptions through the team	Staff will be given clear guidance on their roles and responsibilities as part of the

	training, supervision and development processes at the centre.	meeting and individual staff supervisions. This will be reviewed through team facilitation on the 17th of October 2023.	induction process, probations and supervision by the Centre Manager. This will also form part of the yearly staff appraisal. Director of Service will meet each staff member on an annual basis and staff roles and responsibilities form part of this discussion.