An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 115

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Gateway Children's Services**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Announced Inspection**
Date of inspection:	**12th, 13th and 14th April**
Registration Status:	**Registered from 17th June 2022 to 17th June 2025**
Inspection Team:	**Lorna Wogan** **Paschal McMahon**
Date Report Issued:	**13th June 2022**

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 on the 17th June 2016. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from the 17th June 2019 to the 17th June 2022.

The centre was registered as a multi-occupancy centre to provide medium to long term care for two young people (boys and girls) from age thirteen to seventeen years on admission. The centre aimed to help children recover from adverse life experiences. The model of care was built on a strengths-based approach. The approach to working with children was informed by both attachment and resilience theories. The approach was also trauma informed and staff received training to understand the impact of trauma on child development as consistent with their application for registration. The staff team aimed to increase protective factors and promote resilience by providing a safe environment, access to positive role models, opportunities to learn and develop skills and to build a sense of attachment and belonging. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.2
4: Health, Wellbeing and Development	4.3

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 26th May 2022 and to the relevant social work departments on the 26th May 2022. 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 30th May 2022. 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: 115 without attached conditions from the 17th June 2022 to the 17th June 2025 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 inspectors found the premises were suitable to meet the needs of the young people and the environment was suitable to provide safe and effective care. The home was clean, appropriately decorated and maintained in good structural condition. The centre layout and design provided suitable spaces for recreation and activities, space for privacy and rest and a spacious communal area for mealtimes. There was evidence of on-going improvements to the environment. There was one bathroom on the premises that the young people shared and there were no issues around privacy or access to the bathroom for the young people. There laundry facilities were suitable and the centre was adequately lit, heated, and ventilated. A review of the maintenance log evidenced that maintenance issues were dealt with in a prompt manner and there were no open maintenance issues at the time of the inspection. There were lots of personal touches to the centre and the young people could display or keep personal items around the house. The young people had their own bedroom where they could secure personal items. They had opportunities to personalise their rooms and had sufficient space for storage. One young person displayed family photos and personal memorabilia in their bedroom along with their wide range of books that were displayed in a bookcase. This young person's love of reading was supported and encouraged by the team. The spaces in the house were adapted appropriately to meet the needs of two teenagers for example electronic games, punch bag, board games and art materials. There were two sheep in the grounds of the centre the young people had reared since they were lambs. The inspectors found that the young people engaged periodically in activities with staff in the house like baking, art/craft work and playing cards.
Each young person had their own comfortable television room that provided individual space to relax. The young people were expected to maintain their

bedrooms to a reasonable standard and there were routines in place to keep their rooms clean and this was confirmed by one of the young people who spoke with the inspectors. A quality audit undertaken by the external quality auditor was completed on the premises and an action plan developed to address required actions and was signed off by external managers. There was evidence on the individual work records and in house meetings that young people were consulted and had opportunity to be involved in buying items for the house based on their needs.

The centre had written confirmation from a certified engineer that all statutory requirements relating to fire safety and building control had been complied with. The centre maintained a fire register on site which was reviewed by the inspectors. The centre had a named fire safety representative. The fire evacuation plan was displayed in the centre and the assembly point was identified. Maintenance checks were carried out on fire alarm and emergency lighting as required and evidenced on the fire logbook. There was a certificate of inspection of firefighting equipment dated 12/02/2022 confirming all equipment was serviced and tested. There was a fire risk assessment logbook and a fire drill record book. From the records reviewed there was no evidence that the young people had participated in a fire drill in the nine months prior to the inspection. The young people had declined to participate in fire drills however this was not accounted for in the centre risk register outlining additional controls/mitigation measures in place. The centre manager must also ensure that each staff member participates in a fire drill at least once a year in line with the centre's safety statement. There was a template for undertaking fire risk assessments, which identified hazards and actions to be taken and these were completed on file. The centre staff also completed a night-time fire log before going to bed each night. There were some gaps in fire training for staff members and there were scheduled dates for fire safety training for these staff. For staff who had undertaken the fire safety training a practical demonstration on the use of firefighting equipment was incorporated into the training. The names and dates of staff fire safety training were not identified on the fire register as required however fire safety training certificates were held on the staff personnel files.

There was a safety statement and health and safety policy in place and a named health and safety representative. The health and safety representative and the first aid responders were not named on the safety statement as required and staff members had not signed the safety statement. The safety statement was developed in November 2020 and there was no evidence it was reviewed annually as required under the legislation. The inspectors found that some centre practices and centre specific risks were not aligned to the safety statement developed in November 2020.

The safety statement and the risk assessment section of the statement must be reviewed annually and updated as appropriate in line with the Health, Safety and Welfare at Work Act, 2005. The centre also had a health and safety policy that was not fully aligned to the safety statement or specifically to the operation and location of the centre. There was no evidence this policy had been updated by the centre manager or the health and safety representative in February 2022 as set out in policy.

The health and safety representative conducted health and safety checks every three months and completed a detailed written report on their findings. Checks on the condition of electrical items and furnishings were undertaken and adherence to health and safety measures in the centre were reported on. Gaps and deficits were identified and evidenced as rectified. The centre staff also completed a weekly risk/hazard assessment of the premises that noted presenting risks in the environment and preventative measures in place. The centre had measures in place for the management of Covid-19. There were daily and weekly cleaning schedules in place and weekly stock checks were undertaken to monitor PPE supplies and sanitization products. Medicines were stored in a secure cabinet with separate locked areas for each young person's medication.

There was a training schedule in place for staff to undertake mandatory training in fire safety, first aid and manual handling. Team members also undertook anti-ligature training and training in the safe administration of medication. Most of the team members had undertaken first aid responder (FAR) training and there were plans for the remaining members of the team to undertake first aid responder training or refresher training as required. Refresher training was completed every two years. Training certificates were maintained on the staff personnel files reviewed by the inspectors and the manager maintained a monthly tracking system to monitor staff training requirements.

The centre maintained an accident/injury log. There was a pro forma for recording accidents and actions taken to minimize the risk of such accidents reoccurring. The inspectors found there were appropriate responses to these accidents set out on the accident/injury log. There were clear procedures in place for recording and reporting accidents and injuries sustained by staff in the workplace in line with the Health, Safety and Welfare at Work Act, 2005. There was one such accident that was reported within the last year and identified actions taken to minimize the likelihood of a similar accident occurring again.

The centre had two vehicles to transport the young people. The centre vehicles were found to be clean, roadworthy, regularly serviced, insured, taxed and driven by staff who were legally licenced to drive the vehicles. Copies of full driving licences were evidenced on the personnel files reviewed by the inspectors. The centre recorded all vehicle maintenance checks and repairs and there were systems in place to undertake weekly cleaning and checks on the centre vehicles.

House maintenance requirements, fire safety and oversight of cars was evidenced as standing agenda items at team meetings.

Compliance with regulations	
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 centre manager must ensure that where young people decline to participate in fire drills this is noted on the centre risk register with controls measures in place to mitigate the risk.
- The centre manager must ensure that each staff member participates in a fire drill at least once a year in line with the centre's safety statement.
- The centre manager must ensure the names and dates of staff fire safety training are recorded on the centre fire register.
- The health and safety representative and the trained first aid responders must be named on the register in line with the legislation and staff members must sign the safety statement to evidence they have read and understood it.
- The centre manager must ensure the safety statement is reviewed annually and updated as required under the legislation.

- The centre manager must also ensure the centre's health and safety policy is fully aligned to the safety statement and specifically to the operation and location of the centre and is reviewed and updated as set out in the policy.

Regulation 5: Care practices and operational policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

There were policies and procedures in place to guide staff in the management of behaviour. The behaviour management and practice policy outlined the focus on responding to pain-based behaviour and staff interviewed were able to describe this approach and how it fitted with their model of care and their behaviour management intervention. The staff interviewed were able to describe how they promoted positive behaviour though their understanding of trauma, attachment-based approaches to care, active listening, empathy, and behavioural support techniques. Staff had access to up-to-date knowledge and skills and were provided with relevant training and support from the behaviour management trainer and the consultant attachment specialist. There were records maintained of guidance and direction provided by professionals external to the centre. There was also evidence of effective communication with an external psychologist who was engaged by the organisation to support one of the young people. This young person had complex needs and staff had pursued appointments with child and adolescent mental health services and with the local youth advocate programme.

There was evidence in both key work and individual work that the young people were made aware of the expectations around their behaviour and the consequences for poor behaviour. There was a strong focus on repairing relationships for example encouraging young people a to write letter of apology or verbally apologize and an expectation that when staff returned on duty following an incident, they acknowledged for the young person the challenges of previous shift. There was evidence that the attachment specialist guided staff in their approach to repair relationships along with setting out expectations to help build and maintain positive healthy relationships. The centre maintained a consequences log that was up to date and outlined the consequences implemented in response to a particular behaviour or incident. The inspectors found that overall, the consequences recorded were linked

to the behaviour and supported learning for the young people. However, the inspectors found there was no evidence on the log of oversight by the centre managers over the past twelve months or evidence of any commentary from managers on the effectiveness of the consequences implemented.

The centre had a written policy on the management of significant events and there was evidence that social workers were notified of significant events both verbally and in writing in a timely manner. The centre maintained a register of all significant events. Following the review of significant event reports the inspectors found that staff responses to the young people in crisis reflected responses that were in line with the centre's model of care, the guidance provided by the attachment specialist and the behaviour management system. Significant events were reviewed at the monthly senior management meetings and learning outcomes and alternative intervention strategies were identified on the team meeting records. The significant event review group procedure within the organisation was recently further developed. The behaviour management trainer set out the terms of reference for the significant event review group and a pro forma for the review of such incidents at the senior managers meeting with a focus on reflective practice and learning. The inspectors recommend that a more detailed analysis and assessment of whether staff interventions reduced risk and increased safety is specifically undertaken in the management review of significant events to further enhance the learning for staff. The behaviour management trainer identified the significant events for review at the managers meetings. The inspectors are of the view it would also be beneficial to give staff the opportunity to identify significant events they would like reviewed by external managers to provide them with the opportunity to input into the review process.

There was evidence of planning at team meetings to manage behaviour that challenges. Significant events were discussed, and the outcomes of these discussions were recorded. There was an evident focus at team meetings on the need for consistency within the team as recommended by the consultant attachment specialist. The inspectors found that staff attendance was low at both the monthly attachment training and at team meetings however there was evidence that the centre manager had recently raised this concern with the team and attendance at the most recent team meeting was improved.

An external quality assurance auditor had undertaken an audit of the centre practices under Theme 3 of the National Standards for Children's Residential Centres, 2018 (HIQA) in March 2021. During the past year the auditor had further developed the audit report template and had developed a schedule of audits for the centre for 2022.

The audit report dated March 2021 did not provide a sufficient or robust analysis on the centre's approach to managing behaviour, how incidents were recorded and reviewed, learning outcomes, the effectiveness of staff interventions and the capacity of the staff team to respond safety and effectively to the young people's presenting behaviour in line with Standard 3.2. Where centres are experiencing a high level of behaviours that challenge over a period of time and risk associated with the management of such behaviours increases the inspectors recommend more focused external auditing of specific aspects of the care practices in this case the safe management of behaviour that challenges.

Both young people had individual crisis management plans and absence management plans that were comprehensive and up to date. The staff were trained in a recognised behaviour management intervention. At the time of the inspection refresher training for all core staff members was up to date with two refresher trainings undertaken by staff in January and April 2022 to include refresher training in physical restraint interventions. Training certificates were held on the staff personnel files. The inspectors found that refresher training for one relief staff member was out of date and prior to refresher training completed in 2022 the behaviour management training for one member of the core team was not in line with the training requirements. The centre manager confirmed to the inspectors that these staff members had not undertaken any physical restraint interventions during the period where their training was out of date. There was no evidence that this matter was identified as a risk by the centre manager or identified as a risk on the centre's risk register.

The individual crisis management plans for both young people indicated that physical restraint was a permitted and agreed intervention strategy to support crisis behaviour. Physical restraint intervention was employed as required on ten separate occasions for one young person over the past twelve months to keep both staff and young people safe. The physical restraint interventions were reviewed by the behaviour management trainer to ensure the interventions were used correctly. There was evidence of life space interviews attempted by staff with the young person concerned following incidents of restraint however despite the efforts of staff there was limited engagement in the process. At the time of the inspection visit, inspectors found that the centre was experiencing a period of crisis with difficulty keeping this young person safe and additionally keeping the staff safe when dealing with high-risk behaviour. The inspectors recommend that the behaviour management plan for this young person is reviewed by the centre managers, external managers, the behaviour management trainer, and the social work team to assess the safety and suitability of

restraint interventions for this young person. In consultation with external professionals, in addition to the current behaviour management strategies, the Gardaí were to be notified and requested to assist staff in high-risk situations. The inspectors found this additional intervention strategy was not included in the updated individual crisis management plan. The young person was very unsettled in their placement at the time of the inspection and had requested to move to an alternative placement. A meeting was recently undertaken with the service managers, the social worker and the principal social worker to look at alternative care options to respond to the complex and challenging needs of the young person. The young person spoke with the inspectors and stated they did not feel well supported by staff in relation to their behaviour. Two weeks prior to the inspection an external professional notified the centre managers that the young person had indicated to them that they sustained an injury in course of a restraint intervention and a mandated report was submitted to Tusla by the centre staff. There was also evidence on the care records that staff members supported and facilitated the young person to make a complaint to the local Gardaí. However, in the interim the social worker and the centre manager agreed that the service director who was external to the centre would investigate the allegation. The centre manager did not maintain a record of this discussion or the decision taken with the social worker on the young person's care record. This course of action was not in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the centre's own written child safeguarding policy to the management of an allegation of harm. Equally in this regard the young person did not feel their concerns were independently heard, investigated or addressed at the time.

Risks in relation to behavioural presentation were identified and subject to structured risk assessments. The centre had developed a comprehensive and clear pro forma for risk assessing the individual behaviours of the young people that set out mitigation measures. There was evidence that when additional mitigation measures and controls were put in place the risk was re-evaluated on the matrix system. While there was some evidence that risk assessments were reviewed at team meetings there was no date identified on the risk assessment to indicate when they were reviewed, by whom or the outcome of the review. The centre manager stated that risk assessments were forwarded to the social workers. However, there was no evidence on the care records that they were sent to the social workers and the date they were sent.

There was evidence that restrictive practices in place were risk assessed and evidenced as required due to a serious risk to the safety and welfare of a young person

or others. The behaviour management and practice policy outlined that all restrictive practices must be risk assessed, monitored, and reviewed monthly by key workers and house managers however the inspectors could not find evidence of these reviews, the risk assessments outlined they would be reviewed quarterly. The review of restrictive practices must be evidenced on the care records detailing the outcome of the review for example, if they are still required or can be minimised. The centre manager must also ensure there is evidence on file of consultation with the young person's social worker and family members in relation to the use of restrictive practices for the individual young people.

Compliance with regulations	
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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre managers must ensure they have oversight of the consequences log and evidence their findings in relation to the appropriate and effective use of consequences for the young people.
- The senior service manager in conjunction with the behaviour management trainer must ensure that within the SERG process there is a more detailed analysis of staff interventions and assess specifically if such interventions reduced risk and increased safety to further enhance the learning for staff.
- The service director must ensure that where staff teams are experiencing a high level of challenging behaviours over a sustained period and where the risks associated with the management of such behaviours increases over time a more focused and detailed external audit should be undertaken in specific areas of practice as required. In this case the safe management of behaviour.
- The centre manager must ensure that when staff training in the behaviour management system is not compliant with the requirements of the programme this must be risk assessed and recorded on the centre register.
- The centre manager and other relevant professionals must review and assess the safety and suitability of the restraint interventions agreed on one of the

young person's individual crisis management plan. The agreed intervention of the Gardaí must be included in the young person's individual crisis management plan.

- The service director and the centre manager must ensure that the investigation of any allegation of harm is compliant with Children First National Guidance for the Protection and Welfare of Children, 2017 and is also managed in compliance with the centre's written child safeguarding policy.
- The centre manager must ensure there is evidence on the care records of the review of risk assessments and outcome of such reviews is recorded. The records must also show that risk assessments have been agreed with and forwarded to the allocated social workers.
- The centre manager must ensure there is evidence on file of consultation with the young person's social worker and family members in relation to the use of restrictive practices for the individual young people.

Theme 4: Health, Wellbeing and Development

Standard 4.3 Each child is provided with educational and training opportunities to maximise their individual strengths and abilities.

The inspectors found that each child was provided with educational opportunities to maximise their individual strengths and abilities. Both young people were in educational placements at the time of the inspection. On admission one of the residents was re-registered in a previous school they attended to provide some consistency in relation to their education. The young person's views were central to this decision despite the distance from the centre to the school. One young person had recently secured an alternative educational programme and they informed the inspectors that the staff supported them well in relation to their education. Supplementary tuition was offered to the young people as required as was after school study. The young people did not require any specialist educational assessments. There was appropriate facilities and quiet space in the centre for the young people to complete their studies. There were clear staff expectations in relation to homework and study routines.

When one young person was out of their educational placement the attachment specialist advised the team in relation to the importance of structuring their day. The team meeting records evidenced the team developed plans to structure the young

person's day when out of school. The centre maintained a record of all days absent from educational placements and could account for all absences.

There was evidence on key work records of regular discussions with one of the young people about their school progress and their application to their work. The team were guided by the centres attachment specialist in ways to support and encourage the young person to reach their educational potential.

There was evidence of regular communication with the educational providers maintained across the electronic care files. Staff attended parent teacher meetings and records were maintained in relation to these meetings. Individual work was undertaken with the young people in relation to their education to address challenges they faced in their educational placements along with praise and positive reinforcement for achievements in relation to their education. There was evidence that staff involved the young people in planning around their education and discussed with them the best options in relation to meeting their educational needs.

The individual education folders for the young people that were maintained electronically contained very limited information, with only two school progress reports on file for one young person and a copy of State exam results for the other young person. The centre had moved to electronic case management system over twelve months ago however there was little information in this section of the file to evidence their educational history to date. The inspectors advise that all information related to the young person's education and their progress including correspondence from the schools, attendance records, meetings with the educational providers, outcome of parent teacher meetings, school application forms are all stored in the educational section of the electronic file to track their educational history and are accessible for inspection purposes.

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 4.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that all records relating to the young people's education can be easily located on the care records and that a comprehensive record is maintained of their educational history and educational progress during their time in the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that where young people decline to participate in fire drills this is noted on the centre risk register with controls measures in place to mitigate the risk.	The centre manager will ensure that the centre risk register is updated to include young people declining to partake in fire drill is included as well as all control measures to mitigate risk. Commencing June 2022.	Centre risk registers will be reviewed as bimonthly as part of the centre's team meetings to ensure it accurately reflects the risks involved. Risk registers will be reviewed biannually by senior management. Risk registers will also be reviewed as part of the centre's quarterly audits.
	The centre manager must ensure that each staff member participates in a fire drill at least once a year in line with the centre's safety statement.	The centre manager will review this with the appointed fire safety officer to ensure this occurs. The centre manager will review the fire drill log monthly to ensure compliance. Commencing June 2022.	This will be reviewed as part of the centre's quarterly audits.
	The centre manager must ensure the names and dates of staff fire safety training are recorded on the centre fire register.	This has been completed. April 2022. The centre manager will ensure this is updated when new staff begin working in the centre.	This will be reviewed as part of the centre's quarterly audits. The senior service manager will review fire safety/health and safety documentation on

			centre visits biannually.
	The health and safety representative and the trained first aid responders must be named on the register in line with the legislation and staff members must sign the safety statement to evidence they have read and understood it.	The register has been updated to include the health and safety representative and all trained first aid responders and all staff have read and signed. (April 2022)	The register will be reviewed biannually as part of the team meeting. The register will be reviewed by QA co-ordinator as part of the centre's quarterly audits.
	The centre manager must ensure the safety statement is reviewed annually and updated as required under the legislation.	The centre management team will review the safety statement annually in consultation with senior management. Commencing June 2022	The director of operations will review and sign off on the safety statement annually once all are in agreement that this document is updated and appropriate. This will be reviewed as part of the centre's quarterly audit.
	The centre manager must also ensure the centre's health and safety policy is fully aligned to the safety statement and specifically to the operation and location of the centre and is reviewed and updated as set out in the policy.	The centre manager will review the policy to ensure that it is fully aligned with the centre's safety statement and that this is reviewed and updated as set out in the policy. This will be escalated to senior management for approval. July 2022.	The director of operations will review and approve. Policy and procedure development policy has been implemented which outlines schedule for review of all organisational policies.

3	The centre managers must ensure they have oversight of the consequences log and evidence their findings in relation to the appropriate and effective use of consequences for the young people.	The centre managers will ensure that their oversight of the consequence log is evidenced and that consequences and the effectiveness of these are reviewed by both the management team and as part of the centres regular team meetings. Commencing June 2022.	The senior service manager will review consequences in the centre during visits to the centre. This will also be reviewed as part of quarterly audits.
	The senior service manager in conjunction with the behaviour management trainer must ensure that within the SERG process there is a more detailed analysis of staff interventions and assess specifically if such interventions reduced risk and increased safety to further enhance the learning for staff.	This SERG process has been further developed to include a more detailed analysis of staff interventions and the effectiveness of these, this commenced 03.05.22.	SERG process is a standing item on the senior management meeting agenda monthly. Training manager ensures that all SEN's are circulated for review prior to the meeting and records all feedback accurately. Any feedback to teams is provided by centre managers. Evidence of same is included on management meeting minutes.
	The service director must ensure that where staff teams are experiencing a high level of challenging behaviours over a sustained period and where the risks associated with the management of such behaviours increases over time	The service director will ensure that this occurs, where required. Commencing June 2022.	The service director has oversight of all SEN's that occur in the centre. Organisational escalation process in place.

	a more focused and detailed external audit should be undertaken in specific areas of practice as required. In this case the safe management of behaviour.		
	The centre manager must ensure that when staff training in the behaviour management system is not compliant with the requirements of the programme this must be risk assessed and recorded on the centre register.	The centre manager will ensure that this is risk assessed and added to the centre risk register, where required. Commencing June 2022.	Centre risk registers will be reviewed bimonthly as part of the centre's team meetings to ensure it accurately reflects the risks involved. Risk registers will be reviewed biannually by senior management. Risk registers will also be reviewed as part of the centre's quarterly audits.
	The centre manager and other relevant professionals must review and assess the safety and suitability of the restraint interventions agreed on one of the young person's individual crisis management plan. The agreed intervention of the Gardaí must be included in the young person's	The young persons Individual crisis support plan (ICSP) has been updated to include Garda intervention. Completed April 2022 The centre manager will review and assess the safety and suitability of identified physical restraint with all relevant professionals including the staff team to	ICSP's are reviewed and updated monthly by keyworkers. Once updated they will be forwarded to the young person's allocated social worker and Organisations in-house TCI trainer for review and agreement. All incidents of physical restraint are completed as SEN's and forwarded to

	individual crisis management plan.	ensure safety and suitability. Ongoing.	relevant professionals, Including allocated social worker and TCI trainer, for review. Additional training can be provided if deemed to be required.
	The service director and the centre manager must ensure that the investigation of any allegation of harm is compliant with Children First National Guidance for the Protection and Welfare of Children, 2017 and is also managed in compliance with the centre's written child safeguarding policy.	The service director will ensure that any investigation of an allegation of harm is carried out in line with relevant legislation and in consultation with the allocated social worker and duty child protection social worker. Ongoing.	Organisational child safeguarding training is currently being developed and will be completed July 2022. This will be provided to all staff and management and has been developed in consultation with the local children's first officer. Child safeguarding will be reviewed as a standing item on both the team meeting and senior management meeting agenda. This will also be reviewed as part of the centre bimonthly audits.
	The centre manager must ensure there is evidence on the care records of the review of risk assessments and outcome of such reviews is recorded. The records must also show that risk assessments have been agreed with and	The centre manager will ensure going forward that the review and updating of risk assessments is included on the young person's care records and that there is evidence of agreement from social work included on these records. Commencing	Young people's individual risk assessments will be reviewed as part of the centre's team meetings. Any changes to these will be noted and forwarded to social work for approval. This process will be reviewed as part of the

	forwarded to the allocated social workers. The centre manager must ensure there is evidence on file of consultation with the young person's social worker and family members in relation to the use of restrictive practices for the individual young people.	June 2022. The centre manager will ensure that there is evidence on file of consultation with social work and family (where appropriate) with regards to restrictive practices for individual young people. Commencing July 2022	centre's quarterly audits. This will be reviewed as part of the centre's quarterly audits.
4	The centre manager must ensure that all records relating to the young people's education can be easily located on the care records and that a comprehensive record is maintained of their educational history and educational progress during their time in the centre.	The centre manager will ensure that more comprehensive records are maintained in relation to each young person's educational history and progress and that these are easily accessible. Commencing June 2022.	The QA co-ordinator will review these as part of the centre's bimonthly audits.