An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 118

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Harmony Residential Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**06th, 07th and 08th March 2023**
Registration Status:	**Registered from the 09th September 2022 to the 09th September 2025**
Inspection Team:	**Cora Kelly** **Lisa Tobin**
Date Report Issued:	**24th May 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 on the 09th of September 2016. At the time of this inspection the centre was in its third registration and was in year one of the cycle. The centre was registered without attached conditions from the 09th of September 2022 to the 09th of September 2025.

The centre was registered as a multi-occupancy service to provide medium to long term residential care for four young people aged 13 to 17 upon admission. The model of care was described as being informed by the principles of cognitive behaviour therapy delivered through a therapeutic relationship. The team aimed to meet a number of the young person's needs, primarily the need to feel safe and to build the young person's self-esteem and confidence and to provide more appropriate skills to express their feelings. There were two young people living in the centre at the time of the inspection. A third young person who was placed under the Tusla derogation process was discharged on a planned basis three days prior to the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
2: Effective Care and Support	2.1
3: Safe Care and Support	3.1
4: Health, Wellbeing and Development	4.2

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, the centre manager and to the relevant social work departments on the 6th of April 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 senior quality assurance manager returned the report with a CAPA on the 18th of April 2023. Upon review the inspectors requested a further review of the CAPA be undertaken with the final CAPA received on the 25th of April 2023. 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: 118 without attached conditions from the 09th of September 2022 to the 09th of September 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

It was the inspector's findings that centre management and staff consulted with the young people in placement, listened to them and encouraged them to be involved in planning their daily living arrangements and overall care. The centre's policies on children's rights and consultation with children guided practice in this regard with procedures to hear the voice of young people in place. These included the facilitation of young people's meetings, keyworking sessions and the completion of weekly planners, monthly goal planners and placement plans. The review of related records by the inspectors evidenced that each of the procedures were followed and good engagement by the young people was found.

There were opportunities for the young people to provide feedback and make complaints with the latter being an agenda item for discussion at the weekly young people's meetings. At these meetings the inspectors noted that on occasions where young people were expressing an opinion about a topic or issue staff responded by offering complaints forms in an effort to manage the young people venting their thoughts and feelings that could have been dealt with through conversation alone. The inspectors recommend that centre management considers how often complaints are discussed with young people at this forum to prevent complacency and a complaining culture being developed.

In interview, the centre manager stated that the organisation's policies and procedures were updated in February 2023, but they were not aware if the complaints policy was updated. The complaints policy was last updated in January 2023 in response to an ACIMS inspection of a sister centre in November 2022. The updated policy included changes to the informal grievance report and centre register, that all complaint records must be shared with the organisation's complaints officer and the development of a new tracker to record complaint trends and patterns. The two categories of complaints, formal and informal, in addition to the four grades for

managing complaints were outlined in policy. The grades of complaints followed an A-D system with procedures stated at each grade. Separate forms were in place to record formal and informal complaints.

The centre was maintaining a complaints register and stored all complaint records in a single complaints folder. On the inspectors review of these a number of deficits were found regarding the overall implementation of the centre's complaints procedures. Since the last ACIMS inspection of the centre in June 2022 a total of eight complaints, four informal and four formal, were recorded on the complaints register. Seven of these were recorded as being made by young people and one by a parent. One formal complaint was open at the time of the inspection with efforts to resolve the issues in the complaint observed. However, on review of the notification of significant event (SEN) register eight formal complaints alone were entered on to that register. Records for six of these formal complaints were not found in the complaints folder or the young people's care files.

As mentioned above deficits were found in staff's understanding and interpretation of what constituted a complaint as opposed to a young person expressing their opinion and, in the recording, and storing of complaints. Similar findings that pertained to recording of complaints was found in the ACIMS inspection of the organisation's sister centre in November 2022. It was stated to the inspectors in interview with the centre manager and staff that young people had sometimes written their own complaints. The inspectors did not find any evidence of this as all eight records reviewed were made by staff on behalf of the young people. There was no evidence of young people being informed that complaints were made on their behalf. The inspectors found that two of the informal complaints did not amount to a complaint and that two informal complaints were logged on one record, none of the complaint forms were completed in full, young person's responses to the outcome was not recorded and the format of the forms varied across some records. The forms did not sufficiently include all sections required that would allow one to observe the start, middle and end of a complaint, record the outcome and young person's feedback. The format of the complaint forms did not include a section to state if a complaint was upheld, not upheld, or withdrawn and there was lack of signatures by young people, staff or management across all records. In follow up to the ACIMS inspection of a sister centre in November 2022 it was stated in the accompanying CAPA that the revised complaints form was to be implemented across the organisation from the 09th of January 2023. There was no evidence to suggest that this occurred for this centre. Lastly, the complaints folder contained records that dated back to 2020 and related to young people who had been discharged from the centre. Complaint records were

not being stored on each young person's care files, as required. Considering all of the above-described deficits regarding the centre's complaints system more robust oversight is required by senior management and the senior quality assurance manager.

The centre's young person welcome booklet included information relating to complaints. Young people were provided with four stamped addressed envelopes if they wished to make a complaint externally to their social worker, through Tusla 'Tell Us', the advocacy support service Empowering Young People in Care (EPIC) and the Ombudsman for Children. It was evident that EPIC was being utilised as an additional support for the young people. Through questionnaire one of the young people named they would speak with staff if they wished to make a complaint. There was evidence of complaint procedures being made known to the young people upon admission to the centre. In interview, social workers for the two young people living in the centre felt the young people were aware of their right to make a complaint and had the knowledge to do so. One social worker further stated that complaints forms appeared to be offered at inopportune times for example in the middle of an incident but that were followed up in the days following such incidents.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **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 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- Senior management must conduct a review of the centres complaints system and ensure that all deficits identified in this report are rectified in a timely manner.

- Senior management must strengthen their own oversight practices to ensure that they identify and address patterns emerging from complaints to improve practices in the centre.
- Senior management must review the updated complaints policy with all working in the centre to improve their knowledge of the complaints system.
- Senior management must review the complaints form and make any necessary changes to ensure it correctly captures all information relating to all stages of the complaints process, including feedback following resolution and if complaints were upheld, not upheld, or withdrawn.
- The centre manager must review the centre complaints register to ensure that a record of all complaints is being maintained.
- The centre manager must ensure that all sections in the complaint forms are completed in full.
- The centre manager must ensure that all complaint records are stored in each young person's care file and complete this task for young people who have been discharged from the centre.

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.1 Each child's identified needs informs their placement in the residential centre.

The centre had a policy on admissions that took account of both planned and unplanned admissions. There had been two admissions and two discharges since the last inspection in June 2022. The centre had engaged with the ACIMS derogation officer with regard to the last young person who was placed in January 2023 through the derogation process as they were aged below 12 years of age and were outside of the centre's statement of purpose. They were discharged three days prior to this inspection with the other young person appropriately discharged upon their 18th birthday in July 2022. The transition plan allowed the young person to become familiar with the day-to-day living arrangements in the centre, the young people who lived there, and meet with the centre manager, their keyworker, and members of the staff team. Information on the centre was also made available to them.

It was evident that senior and centre management worked collaboratively with the social work departments prior to the admission of the most recent young person to ensure that the placement was suitable to meeting their identified needs and those

young people already in placement. Detailed social history reports were provided and held on their care file. The collective preadmission impact risk assessment (PAIRA), that was unsigned and not dated, included feedback from the social workers allocated to the young people already living in the centre. Whilst both social work departments accepted the referral, members of one social work department had concerns about the potential impact the young person they were allocated to may have on the young person being referred. The concerns related to bullying behaviours. This type of behaviour was rated as high risk in the PAIRA with interventions to respond to it outlined in the risk management plan. The interventions did not include a clear response as to how incidents of bullying would be managed either individually for the young people or as a group to keep them protected, safe and reduce its prevalence and effects. The inspectors did not observe discussions on potential bullying from their review of the pre-admission meeting and transition plan meeting minutes that too were not signed or dated. From the review of centre files, young people's care records and interviews conducted it was the inspectors' findings that the decision by the centre to discharge the young person was due to their significant escalation in high-risk behaviours from known behaviours to what was presented by them in the centre and its impact on the safety of the other young people with bullying, as identified by the senior quality assurance manager, a feature of the overall presenting behaviours in the centre.

Compliance with regulations	
Regulation met	**Regulation 5**
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 2.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- Senior and centre management must ensure that all known potential high-risk behaviours are discussed and suitably planned for at the pre-admission stage of a young person moving to the centre.

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.

The centres model of care that was complemented by a five value systems present in social care practice guided the centre in managing young people's total behaviour. The staff team had been provided with training on the model. Accompanying the model of care were a number of policies aimed at promoting positive behaviour that were delivered through a therapeutic relationship between staff and young people. These included behaviour management, consequences, the management of challenging behaviours, restraint, and restrictive practice. Staff in interview demonstrated some understanding and knowledge of the policies, further improvement across the policies was identified by the inspectors.

The inspectors were informed that all staff had been trained in a behaviour management programme yet from the review of the centres training needs analysis it was found that three staff required core training. Refresher training was in date for the remaining staff. The opportunity for the three staff being provided with core training was not available until July 2023, four months after this inspection.

Staff held responsibility for keeping themselves up to date on all plans in place for each young person that guided the management of behaviour, both positive and challenging behaviour. Such plans included individual practice guidelines and behaviour support plans (BSP's). The practice guidelines document was comprehensive that led staff in implementing and following each young person's daily and night-time routines, approved consequences, likes and dislikes, hobbies, and general house rules. The BSP's in their current form were lengthy and the ones reviewed by the inspectors were unsigned. The BSP document had been updated with a newer version developed following a previous ACIMS inspection. It had yet to be implemented in this centre. A plan was in place for this. The BSP's were found to have been reviewed and updated appropriately and the organisations clinical team had oversight of them. The young person discharged from the centre prior to the inspection had been physically restrained, by trained staff, on one occasion with three further attempts to physically restrain them during the same incident unsuccessful.

There was reference in the management of challenging behaviour policy of an additional support mechanism called a behaviour intervention plan (BIP) that had been developed by the clinical team in managing challenging behaviour. BIP's were not evidenced on the young people's files. When this was addressed with centre and senior management in light of ongoing specific behaviours presented by the young people a concrete explanation was not provided.

A token economy system was in operation to promote and encourage positive behaviour and natural consequences were utilised. Whilst this was deemed appropriate for the younger young person the inspectors recommend that they review the system for the older young person given their age and aim of the system being to reduce negative behaviour that should support them in developing better and more positive coping skills.

It was evident to the inspectors that centre management and staff had some awareness of mental health issues and issues such as bullying and how these impacted on the behaviour of young people. However, improvement was required in how such presenting behaviours is responded to and managed. For example, for the older young person who will reach 18 years old in early 2024 they are continuing to present with ongoing self-harming behaviours. Tools were in place to support the young person in responding to their self-harming behaviours. The centre was not actively tracking and monitoring self-harming behaviour incidents and evaluating if the tools were effective. Following the review of all related information and interviews with the young person's social worker the inspectors identified the need for a harm reduction strategy to support the young person, reduce the effects of self-harm on the young person and to include a method of tracking and monitoring incidences of self-harm. The social worker agreed with this. The risk assessment in place for responding to self-harm was lengthy, included a twenty-step treatment plan of which many of the steps required daily implementation by the staff team. According to the young person's social worker the staff team were not consistently abiding by all of the actions so this must be reviewed to ensure it is appropriate and effective.

From the review of the SEN register, a sample of SEN records, daily logs and young people's files the inspectors found that bullying behaviour was a feature in the centre despite centre management and staff having stated in interview that it wasn't a regular occurrence. This may be due to the incorrect naming and recording of it as a named behaviour across various records for example it was referred to as 'negative engagement' or 'engagement with young people' on a number of records. There was

evidence of child protection and welfare reports being appropriately submitted to Tusla through the portal system in response to some bullying behaviour.

There was some evidence of standalone pieces of keyworking on bullying being completed. However, it was not linked or connected to an informed and planned intervention. Where bullying had been identified in SEN's and specific keyworking was named as a follow up action piece namely 'respect for co-residents', there were no keyworking records on file to evidence that it had occurred. There was a pattern of bullying behaviours being a feature upon young people moving to the centre. An escalation in bullying behaviours occurred too when the third young person moved to the centre in January 2023. Despite interventions, as named in the risk management plan being implemented, they did not prove effective due to the escalation of overall risk behaviours in the centre, including bullying, that resulted in one of the young person stating they were afraid, lost, fearful and were locking themselves in their room. An anti-bullying strategy is required to mitigate bullying behaviours, keep them safe and to equip the young people with skills to protect themselves in an appropriate manner. The senior quality assurance manager indicated they would explore this and seek assistance from an external agency.

In line with policy a restrictive practice register was being maintained with restrictive practice assessments stored in a centre folder. On the inspectors review of these assessments the rationale for restrictive practices being implemented was stated. The inspectors identified deficits regarding the implementation of restrictive practices. These included restrictive practice records not being held in young people's individual files, some practices not accounted for as a restrictive practice for e.g., restraints, room and pocket searches and the centres response to managing the older young person's phone use. A social worker for one young person was not aware that restrictive practice assessments were not in place for the latter three practices. For one restrictive practice, that was developed in October 2022, it was reviewed once following its implementation despite being stated on the form that it was subject to weekly review. It was the social workers understanding that they were subject to ongoing review. There was a lack of a specific tracker in place to monitor how often the restrictive practice was utilised to justify its requirement and alleviate the cause of the behaviour. It was evident that restrictive practice measures were impacting on other young people in the centre.

The centre had in place a system for reviewing challenging behaviour in addition to information being contained in weekly reports that were compiled for each young person and were overseen by senior management and the organisations clinical team. An audit on theme 3 of the National Standards for Children's Residential Centres,

(HIQA) that was conducted by the senior quality assurance manager in July 2022 was accompanied by an action plan for implementation by the centre manager in the same month. On their review of the action plan in October 2022 it was found that many of the actions that related to standard 3.2 were outstanding. These related to the behaviour management policy and restrictive practices not being discussed at a team meeting and an internal audit on restrictive practices not completed. These unmet actions were similar to the findings compiled during this inspection. It was further found by the senior quality assurance manager that there was an eight-week gap in a team meeting being held when two should have occurred. During this time a young person had moved to the centre and there was no team discussion until seven weeks after their admission at which stage bullying behaviour had been occurring.

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 manager must ensure that all staff are provided with training in a behaviour management programme in a timely manner.
- The centre manager must develop a harm reduction strategy aimed at reducing the effects of self-harm on one of the young people to include a method of tracking and monitoring incidences of self-harm.
- The centre manager must review the risk assessment on self-harm to ensure its appropriateness and effectiveness in its response to managing self-harming behaviours.
- Senior management must review the policy on anti-bullying with all working in the centre, develop an anti-bullying strategy to mitigate bullying behaviours, keep young people safe and ensure that bullying is being appropriately recorded.

- Senior management must conduct a review of the centres restrictive practices system and ensure that all deficits identified int his report are rectified in a timely manner.
- Senior management must review the policy on restrictive practices with all working in the centre.
- The centre manager must ensure that records relating to restricted practices are stored in the young people's care files.
- Senior management must have greater oversight of behaviour management practises in the centre to ensure the positive provision of positive behavioural support and safe practices.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The centre developed a standalone policy on medication administration and management in December 2022. Prior to this it was part of the centres health and well-being policy. Both young people in placement had dedicated general practitioners (GP). For the third young person who was resident in the centre from January 2023 until their discharge three days prior to the inspection, they continued to access their own GP. The centre manager informed the inspectors that the young person had visited their GP on one occasion. However, there was no record on their care file to verify this. The centre stated they were committed to securing a local GP for them. There was no evidence that two of the young people had attended a medical check-up on their admission and there was no time frame for when this should be completed. One of the young people had been in placement for six months at the time of the inspection. Their immunisation records or medical cards were not found to have been held on their care file either. The centre was making efforts in securing these.

The young people were supported to attend regular dental and optician appointments and the centre was following up with young people's social workers around these. Medical consent forms were on file for all three young people. There was evidence of the young people being supported by staff to attend external specialist support services with one young person linked to Child and Adolescent Mental Health Services (CAMHS).

The young people had been prescribed medications to be taken 'when required' (PRN) with these PRN records stored in each young person's health folder. The inspectors found on review of these that for one young person the times they were due to receive their medication varied from that stated on the prescription. Whilst this was not an error as such, the centre manager stated that in the case of an administration of medication error it would be reported to the relevant professionals through the SEN system. The inspectors found that staff were encouraging the health and wellbeing needs of the young people with goals contained in their placement plans and everyday living routines for e.g., cooking, good personal care, and exercise. Keyworking was found to have been targeting health areas too.

The centre manager had been provided with First Aid Responder training with dates scheduled for staff to complete it. The staff team had been provided with regular first aid training and had completed online e-suicide training completed plus online ligature training. There was a significant deficit in staff being not being trained in self-harm. The senior quality assurance informed the inspectors that they were developing such training. However, given its prevalence in the centre, over a long time, the inspectors recommend that staff are provided with self-harm training as soon as possible.

Compliance with regulations	
Regulation met	**Regulation 10**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must ensure that health records are maintained for medical related events that occur for each young person and are stored on their care files.

- The centre manager must ensure that admission to care medicals are completed for all young people and that medical reports are maintained on their care file. A timeframe for this must be included in policy.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	Senior management must conduct a review of the centres complaints system and ensure that all deficits identified in this report are rectified in a timely manner.	The complaints officer completed a review of the centre's complaint system on the 20th and 21st April to ensure that all deficits identified in this report were evaluated, learning was identified and the issues arising are rectified. An action plan has been developed to rectify the deficits and to ensure compliance.	The centre manager will conduct monthly audits of complaints, and these have been scheduled to take place in May, June and July 2023. The audits will be reviewed in July 2023 by the complaint's officer and will be extended to three monthly reviews if no further issues are identified.
	Senior management must strengthen their own oversight practices to ensure that they identify and address patterns emerging from complaints to improve practices in the centre.	Monthly audits will be completed by the manager and reviewed by the Complaint's officer from May to July 2023. Following this, audits will extend to three monthly reviews if no further issues are identified. Immediate action will be taken if any deficits are identified.	In addition to the monthly audits and review of all complaints as they arise, two further external reviews of complaints will also take place on 20.07.2023 and 26.10.2023 to ensure effective oversight. A quality assurance report will be completed post reviews to ensure no further deficits are arising. Where further preventative measures are required, these will be identified and named via quality assurance report and implemented.

	Senior management must review the updated complaints policy with all working in the centre to improve their knowledge of the complaints system.	To ensure that team are fully aware of the complaint system, senior management will complete the CPD with all team members at the team meeting on the 25.04.2023.	The centre manager will continue to review the application of the complaint's policy - should any deficits be identified, a review of the CPD on complaints will be completed or alternatively, a SER will be completed with the team member/ team. This measure will also be supported via ongoing review of all complaints as they are fully closed by the complaint's officer.
	Senior management must review the complaints form and make any necessary changes to ensure it correctly captures all information relating to all stages of the complaints process, including feedback following resolution and if complaints were upheld, not upheld, or withdrawn.	The updated complaints form now contains sections for: information on complaint, investigation details, outcomes/findings, any actions and if the complaint was upheld, not upheld or withdrawn. The complaints register has also been updated to include in the section "conclusion of the complaint" - it now prompts to note if the complaint was upheld, not upheld or withdrawn. The cover sheet has also been updated to reflect the above. The new documentation has been issued for immediate implementation as of 17.04.2023.	The centre manager will ensure that each time there has been a new step in the complaints process, the form is updated to reflect the update. This measure will also be supported via ongoing review of all complaints as they are fully closed by the complaint's officer.

	The centre manager must review the centre complaints register to ensure that a record of all complaints is being maintained.	Following a QA audit completed in April it was found that there was an error with the recording of significant events on the significant events register relating to complaints. Therefore, this practice will cease, and the centre registers will be updated by 12.05.2023 to reflect same. With immediate effect, the centre manager will be responsible for ensuring that a record of all complaints is maintained and that the practice of noting a complaint on the SEN register.	The centre manager will remain as direct oversight on the complaints register and the significant event register. To ensure issues like this do not arise again, the registers will be reviewed by the regional manager during monthly centre meetings to ensure accurate recording is in place.
	The centre manager must ensure that all sections in the complaint forms are completed in full.	Each time there is an update to a complaint, the centre manager with immediate effect will ensure the form is updated and completed in full.	Upon finalisation of a complaint, the complaint will be shared with the complaint's officer who will oversee the report finalisation and complete the tracker to analyse trends and patterns. Any deficits will be actioned immediately.
	The centre manager must ensure that all complaint records are stored in each young person's care file and complete this task for young people who have been discharged from the centre.	All complaint forms for those young people who have been discharged have been filed in their archived files. The discharge checklist has been updated to rectify this deficit and will be discussed at	The centre is responsible for finalising the discharge process of a young person to ensure all records relating to complaints are placed within the care records. A review of the complaint records will take

		the management meeting on 04.05.2023 and implemented with immediate effect following same.	place in the form of scheduled QA audits conducted by the senior quality assurance manager in line with their scheduled yearly auditing plan.
2	Senior and centre management must ensure that all known potential high-risk behaviour is discussed and suitably planned for at the pre-admission stage of a young person moving to the centre.	On May 4th, 2023, the senior management team and management team of each centre organisation wide are going to discuss the pre-admission process and review the current pre-admission risk assessments and pre-admission meetings along with the current risk management framework and policies. Following this meeting, the regional manager and senior quality assurance manager are going to implement the feedback and review the pre-admission process and risk framework on 10th and 11th of May 2023 and implement revised changes that are required to ensure that high risk behaviours are suitably planned for at the pre-admission stage. By the end of May 2023, any new procedures, updates to policy and procedures will be communicated with all teams and issued	All relevant policies that will require updating post review of the pre-admission process and risk framework will be completed and communicated to all team members. Immediate oversight and governance will be in place from managers and senior managers on any new procedures implemented via the process of accepting a referral for a young person.

		for immediate implementation.	
3	The centre manager must ensure that all staff are provided with training in a behaviour management programme in a timely manner.	Between December 2022 and December 2023 – four trainings have been scheduled to ensure employees receive behaviour management training in a timely manner. However, we will continue to keep this under ongoing review.	The senior manager responsible for oversight on the training needs and the annual training plan will continue to review the needs of the organisation.
	The centre manager must develop a harm reduction strategy aimed at reducing the effects of self-harm on one of the young people to include a method of tracking and monitoring incidences of self-harm.	The centre manager together with the clinical team developed a harm reduction strategy which includes a method of tracking and monitoring incidents of self-harm. The updated documentation was shared with inspectors at time of CAPA submission.	The tracking documents will be reviewed by the clinical team on an ongoing basis for effectiveness and to provide further insight and guidance.
	The centre manager must review the risk assessment on self-harm to ensure its appropriateness and effectiveness in its response to managing self-harming behaviours.	The centre manager has reviewed this risk assessment. A section on the young person's individual behaviour support plan (BSP) has been created to include how the team respond when the young person is presenting at risk of self-harm or has self-harmed. The risk assessment directs the team to the BSP for full guidance on how to respond appropriately to self-harm	The centre manager will review the risk assessment in line with the planned review date or sooner as required to ensure the interventions in place are in use and effective. In addition, as noted above, a full review of the risk framework is taking place in May 2023 which will also include a review of the current risk management plans to ensure these are updated to make

		should it present.	them more effective in terms of guiding team members to respond to any identified risk behaviours.
	Senior management must review the policy on anti-bullying with all working in the centre, develop an anti-bullying strategy to mitigate bullying behaviours, keep young people safe and ensure that bullying is being appropriately recorded.	A full review of the anti-bullying policy will take place and is scheduled for completion by 05.05.23 to include an anti-bullying strategy to mitigate against bullying. The clinical team are developing a bullying training for team members and the procedures outlined in this training will be included in the policy guidance also. A team training is scheduled for 10.05.23 in relation to bullying, this training was developed and is being delivered by the clinical team.	Oversight will continue to take place on all weekly reports and SEN's in the centre by the regional manager to ensure that any incidents of bullying are reported in line with the policy and appropriate action takes place following same.
	Senior management must conduct a review of the centres restrictive practices system and ensure that all deficits identified int his report are rectified in a timely manner.	A full quality assurance audit in relation to centre restrictive practices took place on 14.04.23 by the regional manager. The outcome of the audit was discussed with the team on 25.04.2023. The action plan is due for completion by 09.05.2023.	The centre manager is responsible for ensuring ongoing oversight and review of the restrictive practice assessments. In addition, a review of the centre restrictive practices will take place in the form of scheduled QA audits conducted by the senior quality assurance manager in line with their scheduled yearly auditing plan.

	Senior management must review the policy on restrictive practices with all working in the centre.	The Regional Manager is scheduled to attend the team meeting 25.04.23 during which a full review of the restrictive practice policy will take place.	Should any deficits be identified within the completion of restrictive practices in the future, a review of deficits will be identified, and an action plan will be developed to respond to same. The regional manager will be responsible for oversight and governance in relation to this.
	The centre manager must ensure that records relating to restricted practices are stored in the young people's care files.	The restrictive practice assessments with immediate effect will now be stored within the risk assessment section within each YP's files going forward.	The Regional Manager will review and ensure that these are on file as part of the monthly regional management meetings in the centre.
	Senior management must have greater oversight of behaviour management practises in the centre to ensure the positive provision of positive behavioural support and safe practices.	A joint review will take place including the clinical team, regional manager and centre manager in relation to the positive behaviour management structures currently in place with the centre. This is scheduled for completion 12.05.23.	In the event that a positive behaviour management system is in place for 3 months, a review will take place with the clinical team and centre management in relation to the implementation and continuation of practice to ensure that all plans in place remain effective for the young person's needs. The CAPA is reviewed monthly by the Regional Manager and Centre Manager and these reviews will be planned for in this forum.

4	The centre manager must ensure that health records are maintained for medical related events that occur for each young person and are stored on their care files.	The monthly centre medication audit form was updated on 25.04.2023 to include that all medical related events are maintained in the care files. This revised document will be discussed at the management meeting on 04.05.2023 and implemented with immediate effect following same. The centre manager will discuss this requirement with all team members at the team meeting on 25.04.2023.	The centre manager will be responsible for ensuring that these audits take place monthly to ensure all medical events are stored in their care files. Any deficits will be actioned for completion. In addition, a review of the health records will take place in the form of scheduled QA audits conducted by the senior quality assurance manager in line with their scheduled yearly auditing plan.
	The centre manager must ensure that admission to care medicals are completed for all young people and that medical reports are maintained on their care file. A timeframe for this must be included in policy.	The medication policy will be reviewed in full by 05.05.2023 to include a timeframe for admission to care medicals. As noted above, the monthly centre medication audit has also been updated and will be implemented on 04.05.2023.	The centre manager will be responsible for ensuring that monthly medication audits take place to ensure each child's care record is up to date with all requirements. A review of the admission medical records will also take place in the form of scheduled QA audits conducted by the senior quality assurance manager in line with their scheduled yearly auditing plan.