An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 121

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Terra Glen Residential Care Services Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**14th, 15th and 19th March 2024**
Registration Status:	**Removed from the register on the 10th October 2024**
Inspection Team:	**Janice Ryan** **Ciara Nangle**
Date Report Issued:	**25th November 2024**

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 21st October 2016. At the time of this inspection the centre was in its third registration and was in year two of the cycle. The centre was registered with an attached conditions from 21st October 2022 to 21st October 2025.

The centre was registered as a medium to long term, multi-occupancy service for up to two young people aged thirteen to seventeen upon admission. The centre's model of care was described as a pro-social modelling approach implemented by staff through a relationship based and attachment theory informed framework. There was one young person 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
5: Leadership, Governance and Management	5.4

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

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 person, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 10th May 2024. 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 Director of Operations returned the CAPA on the 28th of May 2024 and this was deemed to be unsatisfactory. A second CAPA was returned to the ACIMS on the 13th of June.

The findings of this report and the assessment of the submitted CAPA deem the centre not to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such based on previous inspection findings and repeated non-compliances, it was the decision of the Alternative Care Inspection and Monitoring Service to escalate this centre to the National Registration and Enforcement Panel (NREP). This report was forwarded to the NREP on the 17th July 2024.

The NREP were not assured that the governance and the management of the centre was in accordance with the standards expected to ensure the wellbeing of young people at this time. The efforts of the centre management to maintain appropriate oversight and quality of care had been insufficient. Accordingly, the agency proposed to remove the centre from the register of services pursuant to Part VIII, Section 61(4) of the Child Care Act 1991.

The centre was removed from the register on the 10th of October 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.

The centre was a dormer style house located in a rural area. The layout and design of the home allowed for the delivery of safe and effective care for a maximum of two young people. There was one young person living in the home at the time of inspection. This young person had access to their own bedroom, which was positioned upstairs, and they had access to their own shower and toilet facilities. At the time of inspection, the inspectors met with the young person who declined to allow them to view their bedroom however, they confirmed they were happy with their bedroom.

There was a large kitchen area with an adjacent sunroom and a separate sitting room that could be used by the young person to enjoy time in the home and have privacy if needed. The inspectors found that there was sufficient indoor and outdoor space to facilitate recreational activities and they observed that the sunroom contained a range of games, boxing bag and activities for this young person. On the day of inspection, the inspectors observed the delivery of a set of goal posts and outside chair for the garden and when they returned to the centre these had been erected.

While the kitchen and sitting room were recently refurbished however, it did not support a warm and homely environment for this young person. The inspectors found that the home lacked aesthetic furnishings and lacked a homely feel, and they found no evidence of display of personal items for e.g. photos/achievements in the home which would contribute to a more homely environment.

Overall inspectors found areas of the house required significant improvements in terms of cleanliness, in particular the toilets and shower areas. Due to the concerns

noted as part of the initial inspection which are discussed further in this report the inspectors returned to the centre a week later to complete a follow up visit.

On arrival to the centre the inspectors found that centre was adequately lit and ventilated however the premises was cold and required a deep clean. The inspectors found that there was a distinct undefined odour around the inside and outside of the house. The inspectors found that there were cleaning schedules in place however, it did not consider the tasks required to deep clean the centre, like washing walls and doors which had become stained over time. On further review of these checks the inspectors found that these checks were not always completed or signed off by staff and the oversight of these tasks required improvement to address these deficits and to ensure the centre was maintained to a high standard.

The inspectors found that the outside spaces were not well maintained, and drains were blocked with leaves and debris and required cleaning. There was broken delph and rubbish thrown in the garden around the house. Where debris had been cleaned from the pump house roof this lay beside the oil tank which may have contributed to a fire hazard. The oil tank was not secure and was not fenced off. The inspectors entered the unlocked garage and found it contained broken equipment and furniture from the home which presented a number of safety hazards and risks. A lock had been placed on the garage when inspectors returned to the centre.

The inspectors acknowledge that the centre had significant property damage over the previous months however the general standard of upkeep which supported a homely environment was not evident.

The inspectors reviewed a sample of individual work and found no evidence that suggested that the young person participated in the decorating of their bedroom or home. However, inspectors reviewed discussions during team meetings where a request had been made to purchase furniture for this young person's bedroom and this has been approved. The inspectors found on review of significant events and other documentation that the young person had requested to move bedrooms on numerous occasions. However, there was a delay in this occurring which had resulted in a significant event. In interview with the centre manager and within the records from the recent team meetings inspectors found that there had been a plan in place for this young person to move rooms and they were being incentivised to engage in positive behaviours to achieve this. However, there was limited evidence of consultation with this young person around their understanding of this plan.

On the day of inspection, the inspectors observed that an extension cable was powering a waste water system in a hazardous manner across the back garden. The outside plug had been placed in a plastic bag underneath a bucket and was located beside the waste water treatment system. The lid on the treatment system was not correctly fitted and as a result was not sealed. The inspectors found that although a risk assessment in relation to this matter was completed on the 8th March and identified a hazard, action was not taken in a timely manner. The risk assessment identified that the waste water treatment system was openly accessible to staff and young people. Ten days later this risk assessment remained opened as it was awaiting maintenance work to be completed.

On review of the centre's health and safety audits the inspectors found that the switches and sockets had been tripping,-that resulted in the centre having no heating for a period of time. Inspectors could not determine for how long this was, as records of maintenance tasks were limited. From a review of correspondence between maintenance and centre management, there was a concern that the waste water treatment system was having an impact on the electrics and work was required to rectify this. Issues with the waste water treatment system appeared to have been on-going since November 2023, when the centre management noted that there was a smell in the bathrooms and linked this to the waste water treatment system.

Due to the issues identified above, and other issues discussed further in this report an immediate action notice (IAN) was issued to the registered provider on the first day of inspection due to significant health, safety and fire concerns identified.

During the course of this inspection and in correspondence submitted in response to the IAN, the inspectors were provided with a variety of explanations from a range of different personnel, staff and management in relation to the rationale for the installation of the extension cable and who completed it. The extension cable was removed following the IAN being issued, however inspectors remained unclear around the rationale for its implementation and how or by whom the issue which required it to be installed in the first instance was addressed.

The centre did not have an effective system of tracking external personnel to the centre, which impacted on inspectors' ability to ascertain who had attended the centre to rectify this issue. This was of particular concern as this presented as a safeguarding risk. While inspectors were asked to sign into a visitors log on arrival at the centre, they were the only entries into this log. A staff member advised the previous pages had been damaged by the previous resident. However, over the course

of inspection, inspectors observed a range of external personnel visiting the centre and there was no further entries into the visitor's log noted. Additionally, inspectors observed the maintenance worker in the centre for extended periods during the inspection. The Director of Operations (DOO) advised that this worker was employed externally to complete works in the centre and therefore not vetted by the agency. Alongside the lack of recording visitors to the centre this is a further safeguarding concern.

The inspectors found that the centre was using different tools to complete maintenance requests. The centre had a maintenance log in place however, this had not been updated since January 2023. The inspectors found evidence that requests for maintenance were being submitted via email and monthly health and safety audits were also completed to track maintenance. The inspectors found that these audits did not always correspond with the requests for identified issues. The audits did not include dates tasks were completed on and inspectors found that some issues remained unaddressed for a number of months. Furthermore, due to the centre utilising different tools the inspectors found that there was no precise tracking of maintenance requests which resulted in the inspectors finding it difficult to track what maintenance issues were outstanding or completed.

The inspectors found that the centre was not identifying significant health and safety issues or fire concerns in the premises which had been ongoing for extended periods of times.

The inspectors found no evidence that the equipment in the centre had been Portable Appliance Testing (PAT) tested to ensure they were maintained and operated in line with manufacturer's instructions. The centre manager in interview was unaware of the need for this to be completed and as such there was no plan in place for this to be completed.

The centre had an organisational safety statement in place dated February 2024. However, this was not a site-specific statement, it did not include specific risk for this centre e.g. the sewage waste treatment system and it did not designate the relevant roles of the fire officers or first aid personnel as required under health and safety legislation. It was not signed by staff or management to indicate that it had been read or understood.

The centre reviewed the environmental risk register in place and found that there was 15 risks categorised since August 2023. The inspectors reviewed the corresponding

risk assessments and found that they were not always in place, up to date or contain the necessary control measures to mitigate the risk. The centre must complete, at least annually a re-assessment of hazards and risks associated with the premises.

The centre had a range of weekly and monthly checks in place to ensure fire safety in the centre. Service checks on the fire alarm system were located at the fire panel and had been completed recently by an external agency. The inspectors reviewed the internal weekly fire alarm checks and found that an issue in relation to the alarm was recorded as a "general disablement" from the 20th November 2023 to the 15th January 2024. As such the fire alarm was not fully functional in protecting the occupants and the building during this period. The inspectors found it difficult to ascertain what the exact cause of this issue was and found no evidence to ensure that the appropriate risk assessments were put in place to address this issue. The inspectors could not find any evidence to say why there was a delay in actively following up on this issue with the relevant service engineers.

Inspectors reviewed records and completed a walk-through of the premises in relation to fire safety and health and safety and noted a number of immediate concerns:

- Checks identified fire equipment to be in place, but the inspectors found that this was not the case. For example, the fire blanket in the kitchen had been removed and was detailed to be in the downstairs bedroom however there was none in place.
- Fire extinguishers had been removed from the communal areas and were locked in bedrooms. Staff had to access these rooms through keys which were not labelled. The inspectors observed staff entering these locked rooms and they noted the length of time it took to identify which key opened each door.
- Two fire doors had been wedged open in the kitchen and sitting room and when the inspectors returned to the premises again one door remained wedged open after being previously highlighted.
- The inspectors observed that eight fire doors were not self-closing.
- Two fire door locks were broken; one in the staff downstairs bedroom and one in previous young person's bedroom and had not been replaced.
- One fire door in the staff office was damaged and required a new door frame to allow for closing.
- The self-closing unit on one of the bedrooms had been broken and not replaced.
- Inspectors found that fire drills did take place however, where a young person did not engage there was no risk assessment or individual work recorded to

address this issue. They found no evidence of a drill being completed in twilight hours.

- Health and safety audits had not highlighted the issues with the fire doors.

As mentioned above the fire equipment had been removed from the communal areas however, when the inspectors asked the centre manager to provide the risk assessment in relation to this, they were unable to locate same until the following day. When provided with same the inspectors found that this risk assessment dated back to August 2022 when a previous resident was in the centre and was not current or reflective of risks associated with the current resident. On review of this risk assessment, it did not highlight what to do in the event of a fire taking place and measures in place were mainly based on the previous resident's (from 2022) behaviour. During the course of this inspection, some of the fire extinguishers were returned to the communal areas and an updated risk assessment was put in place.

The centre had developed an individual fire escape plan for the young person in the centre however, on review of same it contained a different name throughout the plan, and it identified a different location to where the young person was sleeping. This plan had not been reviewed to reflect the change in bedroom and the measures in place were not robust to support the young person to leave the centre in the event of a fire.

On review of a sample of staff personnel files the inspectors could not fully ascertain what mandatory trainings were completed as they did not contain up to date training certificates. The inspectors received a copy of the centre's training register and found that deficits existed in relation to staff completing mandatory training for example, behaviour management, manual handling and fire training. The inspectors found that the systems in place to track staff training and ensure training was completed was not robust and improvement is required. Furthermore, where training was not completed the inspectors found there was no evidence of a risk assessment being completed to address this issue.

The inspectors were provided with an up to date insurance policy which was in place for the centre against accidents or injury to children.

The centre had a system in place for the recording and reporting of accidents/injuries. The inspectors found that there was one recent accident for the young person, and this had been recorded appropriately however the measures in place to mitigate the risk were not practical should this happen again.

There were two vehicles for use by the centre. There were records of regular services of these, they were found to be taxed and insured at the time of the inspection. The inspectors reviewed a sample of personnel files and found that the staff team were licensed to drive these, and records of licenses were recorded on the staff members files except for one staff member. The two vehicles contained first aid equipment, fire extinguishers and hi-vis jackets in the boot however, it may be of benefit to secure the firefighting equipment appropriately to ensure they do not combust whilst driving. The inspectors observed that there was significant damage to the body of the vehicles and on review of the daily car checks in place they found no evidence listing the damage to the car or a plan to address this.

Overall, inspectors found that the systems and records in place to manage and respond to deficits in maintaining the property and identifying health and safety concerns were inadequate and required immediate attention.

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

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

Actions required

- The centre manager must ensure that the centre is cleaned and maintained to an appropriate standard.
- The centre manager must ensure the outdoor spaces are safe, secure and well maintained at all times.
- The centre manager must ensure a maintenance system is in place to track and address maintenance issues and ensure that they are being completed in a timely manner.

- The centre manager must ensure that all equipment for the centre is of an appropriate and accessible standard and is PAT tested to ensure it meets safety standards on annual basis.
- The registered provider and centre manager must ensure the centre complies with the requirements of fire safety legislation and regulations immediately.
- The centre manager must ensure that all staff are appropriately trained in fire safety and all mandatory training is updated in a timely manner and that there is an effective system to track and record this training.
- The registered provider must ensure there is a site specific safety statement inclusive of relevant risk assessments in place. The names and where applicable, the job title or position held of each person responsible for performing tasks assigned to him or her under health and safety legislation should be identified on the safety statement and staff trained as first aid responders must be identified in this regard.
- The centre manager must ensure that all checklists are effective in practice and are accurately recorded.
- The centre manager must ensure that there is an effective system in place to record visitors to the centre.
- The registered provider must put in place the necessary procedures for managing risks to the health and safety of children, staff, and visitors in this centre. This should include a clear and effective risk escalation system that demonstrates knowledge of environmental risks.

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 inspectors found that the quality, safety and continuity of care provided to children in the centre was not effectively reviewed to inform improvements in practices and achieve better outcomes for the young person.

The inspectors found that for the period of September to December 2023 there was only one record of a team meeting on file. Following the appointment of a new social care manager in January 2024 team meetings were in place and the records maintained of these meetings detailed thorough discussions of the young people's care and the operation of the centre. On review of the current minutes the inspectors found discussions highlighted areas for improvements, practice concerns and a lack of training completed by staff in the centre. The inspectors noted that these team meetings were still in their infancy and required a longer period of time to be embedded in the service to ensure quality and improvement of care in the centre.

On review of the training register provided to inspectors following the inspection they found that staff were scheduled to attend mandatory trainings however, had not completed it. While the lack of attendance was referenced within a team meeting inspectors found it difficult to ascertain the reason why it had occurred or the steps that would be taken to ensure that all training was attended.

Prior to the commencement of the new centre manager in January 2024, significant event review group (SERG) meetings had not taken place on a consistent basis and no records were available for inspectors to review for the period following on from the last inspection. The inspectors found no evidence to demonstrate why these had not taken place and there was no documented evidence of oversight of this deficit from external management. On review of the minutes from one SERG meeting that took place in February 2024, the inspectors found that they contained good detail and identified areas for improvement. They highlighted trends and patterns and clear actions for staff to implement to support positive behaviour management techniques

when caring for the young person. Actions arising from this SERG were also discussed in a recent team meeting.

However, on review of two recent significant events for this young person the inspectors found that the plans identified, were not followed by the staff team. Although, action had been taken by the centre manager to address this issue following the first significant event, the same issue arose a number of days later. Staff not adhering to clear plans to ensure the safety of this young person may lead to an adverse event. This was also highlighted by the assigned social worker in interview with the inspectors.

The centre had a range of internal quality checklists in place to review the day-to-day practices in the centre however these checklists were not being utilised effectively and the inspectors found that the information recorded within these documents was not always accurate. They also found no verification of actions completed by the centre manager or oversight from external management.

The inspector reviewed two weekly governance reports completed by the centre manager since they commenced working in the centre. These reports had recently introduced and captured significant detail in relation to the centre and care of the young person however, they did not highlight the deficits identified as part of this inspection. These reports contained oversight and comments from the DOO. The format of these reports provided for external managers to have good levels of oversight in relation to the young person's care and the operation of the centre. However, they would benefit from the inclusion of an action plan with designated people and time frames for follow up. Given these reports had only been implemented, their effectiveness in supporting development of good quality care in the centre could not be assessed at this time.

Inspectors found that monthly management meetings were in place. These meetings included a brief discussion in relation to each of the centres within the organisation, issues arising in relation to care of the young people, staffing, rosters, child protection concerns and complaints. From the records shared with inspectors, the inspectors found that these meetings did not discuss the outcome of audits or ACIMS inspections, and as such the deficits identified as part these processes and the plans put in place to address them was not shared across the organisation which did not support service improvement.

The Acting Operations Manager (AOM) commenced in post in December 2023, and they had completed two internal spot audits in December 2023 and February 2024. These audits were not aligned to the National Standards for Children's Residential Centre's, 2018 (HIQA). The inspectors found that they identified some issues in relation to the Child Protection Welfare Reporting Forms (CPWRFs) (detailed further in this report), and in relation to recording and filing of records relating to the young person. However, the inspectors were not clear on how actions identified were tracked to completion as the audit form was not fully completed. There was no evidence of external managements oversight of the follow up required post audit.

The inspectors found that these audits were insufficient to assess the safety and quality of care provided in the centre as deficits remained. These audits would benefit from a clear action plan inclusive of an identified timeline and person responsible to address same. Additionally, inspectors were not provided with any themed audits aligned to the National Standards for Children's Residential Centres, 2018 (HIQA) to assess the safety and quality of care in the centre.

A quality improvement plan (QIP) had been completed in July 2023 by the DOO. Three areas were identified for improvement which included, recruitment, the upkeep of the centre and support for the staff team. Actions to be taken and by whom were included within the QIP to make improvements in these areas. However, at the time of inspection, 9 months after the implementation of this plan, a number of actions had not been followed and were not in place. Inspectors were not provided with any documentation or records to indicate that this QIP was regularly reviewed or why these actions were not put in place.

Significant deficits were identified in the previous inspection of this service in July 2023. For example, there was limited record keeping in the centre in relation to complaints, staff training and development required improvement, deficits in the tracking of decisions at SERGs, a lack of up to date risk assessments and the provision of supervision. A number of these deficits remained at the time of this inspection. A CAPA had been put in place following on from the July 2023 inspection however inspectors found no evidence of this CAPA being reviewed or discussed with the team or management and the actions remained outstanding. The inspectors found it significantly difficult to track the external governance of the centre due to a lack of records. The inspectors found that the current centre manager had limited knowledge of the extent of deficiencies identified in the previous inspection however was attempting to implement effective systems to ensure safe care for the young person in the centre.

The inspectors sampled a selection of significant events (SENs) for this young person and found at times there was a delay in the reporting of SENs and child protection concerns. In interview staff could articulate what constitutes a child protection concern, however from a review of documentation staff were not consistently identifying or submitting CPWRFs. From the documentation review it was apparent that the submission of CPWRFs was an assumed responsibility of the previous centre manager, and this was confirmed in interview with staff. The inspectors found evidence that all SENs were reviewed by the DOO and where appropriate feedback was provided to the centre. However, inspectors could not see evidence of learning being shared with the team to improve practice and quality of care. Additionally, when the DOO identified actions to be taken, e.g. a retrospective SEN to be completed, inspectors could not find evidence of this occurring or further follow up from the DOO.

The centre had a complaints register in place however, this register had not been updated since September 2023 and there were five open complaints for this young person. Given the lack of detail contained in the register the inspectors found it difficult to track if all complaints were on file, were recorded and investigated appropriately. The inspectors found that an internal audit did not identify the deficits found on inspection and complaints were not analysed for patterns or trends. The inspectors found that in recent team meetings minutes discussion had taken place on how to record complaints.

The centre had a young person's and parent's booklet informing them about the service. Within this the centre indicated that they would request the advocacy service Empowering People in Care (EPIC) to visit the young person within two weeks of admission. The inspectors found no evidence that advocacy services were discussed with the young person or a visit was requested. This was also identified as an action within the 2023 annual compliance report and again in a recent audit completed by the Acting Operations Manager in February 2024. This action remained outstanding at the time of inspection.

The inspectors reviewed the centre's annual review of compliance completed in March 2023. The inspectors found it did not contain an action plan and where actions were identified within the body of the report inspectors could not ascertain how these had been tracked or implemented in practice over the past year. On review of management and team meeting minutes the inspectors could not see where plans to address deficits identified in this report were discussed to ensure a successful outcome.

A social worker was interviewed as part of this inspection and they highlighted some concerns in relation to the implementation of plans for the young person, communication among the staff team and at times delays in the notification of significant events. They did confirm however, that they were promptly notified of serious significant events when they took place. They acknowledged that the centre were caring for a young person with significant behaviours that challenged and identified the difficulties in this.

Overall, the inspectors found the newly appointed centre manager was demonstrating leadership and developing systems of governance and accountability within the team. Given this centre manager had only been in post six weeks prior to inspection it was not possible for inspectors to determine whether the changes in management will be effective in addressing the deficits identified in this and previous inspections and in sustaining improvements going forward.

The inspectors found overall that although there were mechanisms in place to review and audit practice within the centre they did not capture the deficits identified as part of this inspection and had not successfully addressed the issues identified in the previous inspection. The limited records available during this inspection process impacted on the inspectors' ability to comprehensively assess the centre's compliance with the standards and regulations.

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

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

Actions required

- The centre manager must ensure that team meetings take place consistently and minutes are reflective of discussions had.
- The centre manager must ensure that all relevant records are maintained by the centre.

- The registered provider must ensure that a system of audits is devised that supports a systematic review of the day-to-day running of the centre in line with the National Standard for Children's Residential Centres, 2018 (HIQA).
- The registered provider and centre manager must review all significant events to ensure that they are categorised and reported correctly in line with Children's First guidelines and the organisation's complaints policy.
- The registered provider must ensure they evidence oversight and governance of the centre and the auditing system.

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 the centre is cleaned and maintained to an appropriate standard.	The centre manager ensured a deep clean occurred in the centre, and all daily cleaning tasks are completed to an appropriate standard.	The DoO will complete a centre walk around and check cleaning checks biweekly to ensure tasks are being completed.
	The centre manager must ensure the outdoor spaces are safe, secure and well maintained at all times.	The centre manager will ensure to complete environmental health and safety checks of the grounds of the centre weekly, and ensure all deficits are reported/recorded immediately and action plans in place to support repairs required. There has been work completed to ensure this during and since inspection such as garden maintenance, sewage tank fenced off, shed emptied and damaged property deposed of. The oil tank is scheduled to be fenced off by the carpenter on 20th of June.	The DoO will complete a centre walk around and check all outdoor spaces biweekly to ensure tasks/maintenance are being completed effectively and within an appropriate timeframe.

	The centre manager must ensure a maintenance system is in place to track and address maintenance issues and ensure that they are being completed in a timely manner.	The centre manager to ensure the maintenance log is being completed as and when required when any issues arise, to include date of report of issue, and date completed with managers sign off. Also records to be maintained to support follow up if actions not completed within an appropriate timeframe. There are new recording systems in place and a maintenance folder implemented to evidence all records of same.	The DoO will complete checks biweekly to ensure tasks/maintenance are being completed effectively and within an appropriate timeframe to show oversight of same.
	The centre manager must ensure that all equipment for the centre is of an appropriate and accessible standard and is PAT tested to ensure it meets safety standards on annual basis.	The DoO has booked PAT Testing for all centres which are due to take place the week of the 4th of June by an external company. This centre's test was completed on 7th June, awaiting cert of compliance.	The centre managers and DoO will ensure annual PAT tests occur in all centres.
	The registered provider and centre manager must ensure the centre complies with the requirements of fire safety legislation and regulations	The register provider followed up on tasks regarding fire equipment, repairs, and deficits noted by inspection immediately, and sent a compliance letter following a visit from the fire officer.	The centre manager and external management to ensure all issues and actions are identified through audits, and appropriate action plans are in plans to rectify same. Also ensure appropriate risk assessments and recording is

	immediately.		in place to support plans in place.
	The centre manager must ensure that all staff are appropriately trained in fire safety and all mandatory training is updated in a timely manner and that there is an effective system to track and record this training.	All centres have an effective staff training audit in place which is updated monthly by centre managers to highlight to DoO where training is required. At the time of inspection this centre's audit was not updated to reflect same. DoO directed centre manager to complete same post inspection, and also discussed staffs absences in previous trainings and how this could impact staff completing shifts going forward.	The centre manager and DoO will ensure that centre staff training audits are completed and updated regularly so training needs can be identified and sourced.
	The registered provider must ensure there is a site specific safety statement inclusive of relevant risk assessments in place. The names and where applicable, the job title or position held of each person responsible for performing tasks assigned to him or her under health and safety legislation should be identified on the safety	The safety statement is currently being reviewed by the register provider and DoO, and this will be updated in the coming weeks to include recommendations from inspection. Recently the safety statement was updated to include the centre staffs name assigned to fire officer and also staff FAR trained.	The register provider and DoO will ensure the safety statements are reviewed annually to ensure all centre risks and positions held within the centre are continuously up to date with legislations.

	statement and staff trained as first aid responders must be identified in this regard.		
	The centre manager must ensure that all checklists are effective in practice and are accurately recorded.	The centre manager to complete daily checks at handovers to ensure effective oversight. The centre manager will be able then to detect when tasks are not being completed and discuss this with staff. Disciplinary process will be utilised if ongoing.	DoO to complete checks monthly to ensure the centre manager is having good effective oversight.
	The centre manager must ensure that there is an effective system in place to record visitors to the centre.	Visitors log is in place in the centre and the centre manager to discuss with the staff team during next team meeting the importance of utilising same to safeguard the young people.	DoO to complete checks to ensure the centre manager is having good effective oversight.
	The registered provider must put in place the necessary procedures for managing risks to the health and safety of children, staff, and visitors in this centre. This should include a clear and effective risk escalation system	The register provider and DoO will review the environmental risk register and procedures by the 16.06.2024. This will include the recording of risks that are escalated to senior management and there will be effective record keeping to evidence follow up on action plans.	DoO will discuss the procedures for managing risks in the centres with the centre managers at the senior management meeting in June, whereby it will be reiterated the importance of centre managers to complete environmental checks, and to escalate risks to the DoO if not

	that demonstrates knowledge of environmental risks.		actioned in the appropriate timeframe. DoO will then escalate to the DoS. The DoO and registered provider will review the register to include a section for escalation to evidence recordings of same.
5	The centre manager must ensure that team meetings take place consistently and minutes are reflective of discussions had.	Team meetings have been occurring in the centre as DoO attends regularly. However, at the time of inspection the records to support same were not on file. DoO has given the previous centre manager a timeframe to complete all outstanding reports by end of June 2024.	The DoO and AOM will ensure to complete regular audits on files to ensure all records are completed and filed in an effective time frame to support the work completed.
	The centre manager must ensure that all relevant records are maintained by the centre.	DoO and AOM completed work with the centre manager and staff team and discussed the importance of record keeping of centre files, and time management, delegating, and utilising supports if needed.	The AOM and DoO will visit the centre every 2 weeks to spot audit files to ensure the files are being kept up to date.
	The registered provider must ensure that a system of audits is devised that supports a systematic review of the day-to-day running of the centre in line	There is a system in place whereby a themed audit is completed and bimonthly a spot audit will occur to ensure tasks and recommendations are completed.	The register provider and DoO will ensure all auditing systems in place are followed more effectively in the centre in line with the National Standards for Children's Residential Centres, 2018 (HIQA). The DoO will ensure to

	with the National Standard for Children's Residential Centres, 2018 (HIQA).		support the AOM in the role/task of auditing to ensure it is in line with National standards for Children's Residential Centres, 2018 (HIQA).
	The registered provider and centre manager must review all significant events to ensure that they are categorised and reported correctly in line with Children's First guidelines and the organisation's complaints policy.	The centre manager reviews SENs, and DoO reviews all SENs as they are sent to professionals and responds with recommendations and follow ups that is felt is not completed. This was discussed with the new centre manager to ensure understanding of the procedure.	DoO to ensure during audits that these are printed and filed to evidence oversight, and also to ensure all responses are followed up on and evidenced on file.
	The registered provider must ensure they evidence oversight and governance of the centre and the auditing system.	The register provider and DoO have discussed with the new centre manager the importance of evidencing record keeping and auditing systems of files, and the DoO and AOM will ensure that the audits completed going forward will reflect and evidence same. All audits will be shared with the DoS and registered provider for review, and will be discussed in the quarterly scheduled board meetings to ensure oversight and compliance.	The register provider and DoO will devise quarterly plans for audits, and ensure there are timely responses and action plans. This will aid in identifying action plans, and also evidence oversight by senior management. The board have also scheduled quarterly meetings with the register provider and DoO, whereby a report has been devised to include discussions of all centre audits and inspections, and follow up actions for same.