An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: ID136

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Positive Care Ltd**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**25th & 26th March 2021**
Registration Status:	**Registered from 30th May 2021 to 30th May 2024**
Inspection Team:	**Lisa Tobin** **Linda Mc Guinness**
Date Report Issued:	**15th September 2021**

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 Assurance 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 30th May 2018. At the time of this inspection the centre was in its second registration and was in year one of the cycle. The centre was registered without attached conditions from 30th May 2021 to 30th May 2024.

The centre was registered to provide medium to long term care for three young people aged between 13-17 on admission, through a care framework that addresses trauma and attachment from pre-admission/admission risk assessment, stabilisation and planning, support and relationship building and positive exits. There were three children living in the centre at the time of the inspection, one of whom was under a derogation order. The derogation order was in place as the young person was outside the age range of the centre.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.2, 3.3
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1, 6.4

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 people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 6th August 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 19th of August 2021. 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: 136 without attached conditions from the 30th May 2021 to 30th May 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support.

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

The centre had an admissions policy which set out the process of how young people were to be admitted and what information was required and made available to the young people. There was an admission policy in place which identified the requirement of an up to date care plan for each young person. Inspectors noted that all three young people did not have up to date care plans on file. Inspectors reviewed contact information from the centre manager to the relevant social workers requesting care plans. There was no official escalation policy in place regarding this process. It was recommended that the organisation create an escalation policy for the care plans as these are the guiding documents that link to the placement planning of the young people. The young people were encouraged to attend their reviews however if they chose not to, their keyworker would complete relevant work with them to get their views and opinions to ensure their voice was heard at the meeting.

The centre created their own document for the young people on the back of the child in care review minutes taken by a member of the team. The team did not receive minutes from the review from the social work department for these meetings either. From this document, the placement plans for each young person were created. The direction for the placement plans must come from the care plan drafted by the allocated social worker. The young people's needs and goals were addressed in the placement plan. Inspectors noted the link between the care plan, the placement plans to the key working that was carried out with the young people. There was evidence of oversight from the management, keyworkers and the team through reviewing the placement plans at handovers, supervisions and team meetings. Centre management carried out internal audits on the placement plans which identified areas where further work was required.

There was evidence of the young people's participation in the process of placement planning. One young person spoke to inspectors of a goal to work towards more access with family. However, some of the young person's goals were repeated monthly with little or no action taken on these. There must be more emphasis on the young person's goals and achieving those goals in a timely manner. Family were involved with the placement planning process when appropriate and were made aware of the outcomes through contact with staff and social workers.

Inspectors noted that specialist services were being provided for the young people such as play therapy, adventure therapy and CAMHS. Another young person was on the waiting list for anger management support. The most recent young person admitted had a diagnosis of epilepsy. Training in epilepsy was identified and sourced for the team however, this didn't occur until two months after the admission.

The allocated social workers and guardian ad litem reported that the communication between the team was in the majority effective and that they were made aware of the care plan and placement plan updates through the reports received each month.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 2.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure an escalation process was in place to ensure that all young people have their up to date care plan.
- The centre manager must ensure placement plans have more emphasis on the young person's goals and achieving those goals in a timely manner.

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 centre had a policy on behaviour management and the staff members that were interviewed were aware of the policy. Sanctions and rewards were in place for the young people. Inspectors found that previous sanctions in place for one young person were not relevant to the behaviours. These were reviewed with involvement from the wider clinical team and a new traffic light system was implemented which had a more positive impact on the young person's presenting behaviours. Social workers informed inspectors they were notified of all issues within in the centre, including significant events, child protection welfare reports and complaints.

The organisation had a therapeutic CARE framework that was used by the staff in the centre to help with addressing, supporting and promoting positive behaviour. The pillars in the care framework were identified by the staff during interview and in the questionnaires. Staff's knowledge of the care framework and the use of PACE (playfulness, acceptance, curiosity and empathy) and SELF (safety, emotions, loss and future) were noted by the inspectors throughout documents including LSI's, handovers and daily logs. Two of the young people had therapeutic plans drawn up while the other young person had a behavioural support plan in place which was developed by the organisations psychologist. The therapeutic plans were linked with the model of care, PACE/SELF and peace of mind programme.

A working guidelines document was used by the team as a live document which assisted the team in dealing with the young people's behaviours. These were regularly updated by the staff which was noted by inspectors. Daily planners were in place for the young people in order to give them structure and a visual concept of how their week was planned. These were also available in the staff office which allowed staff oversight of each young person's plan for the week.

Staff were trained in a recognised model of behaviour management. Refresher training had been provided however, some staff had only completed the theory aspects and not the physical aspects. Inspectors queried if the appropriate training had been completed by staff for Level 5 of therapeutic crisis intervention, due to a non-routine restraint taking place the same day a staff member had been trained.

Inspectors were furnished with details of the staff's training record and of the SERG that took place after this incident. Appropriate outcomes were outlined following this review, including the staff involved to receive further physical intervention training, they were not to participate in any physical interventions until such time and to complete report writing training.

There was an anti-bullying policy in place. Some staff stated in their questionnaires that bullying was not an issue in the centre however, there had been a number of incidents of peer to peer bullying. Inspectors reviewed numerous complaints by two young people in relation to bullying which were forwarded to the relevant social workers. Inspectors saw evidence that young people attended young people meetings and discussed the ongoing issues. Bullying contracts were signed by each young person. Mediation had taken place between the young people. The ongoing issues of bullying brought about SERG and strategy meetings with both young people's social work departments involved. The SERG identified that there was a lack of planning around the shifts, a lack of communication between the staff, insufficient staff supervision on the floor and a lack of coordination on shift. A social worker highlighted concern to inspectors for the young person affected and how the incidents were being managed by the team. The social worker stated that interventions were not happening quick enough to deescalate the incidents. A further four incidents of bullying requiring child protection welfare report forms occurred after the strategy meetings. As the staff could not manage the environment safely and prevent the bullying behaviour from occurring and impacting on the young person, it was decided that the other young person would need to leave the centre to alternative accommodation. Despite the placement planning and strategy meetings, it was evident that the current structure was not working. The centre manager must ensure that young people are kept safe from peers and that staff respond appropriately to the challenging behaviour in a timely manner, using their recognised behaviour management techniques.

Inspectors reviewed life space interviews (LSI's) that were completed with the young people which identified the triggers and discussed possible alternative behaviours. Follow up work was completed with the young people during key working and individual work. Alternative therapies were also made available such as play therapy. As a response to one young person's behaviours escalating to concerning levels, there was agreement for extra staffing for a six-week period. This was then agreed for a further six weeks as incidents were continuing to occur. However, even with the extra staffing in place, this young person was removed from the centre due to the ongoing impact on the peer. The centre manager must review the pre-admission process and

learnings from this specifically with regard to negative impact young people can have on each other.

The centre audits were carried out both internally and externally including a review of the behaviour management in the centre. Oversight was evident to inspectors through the file review with input from management, senior management, the clinical team and from the TCI trainer. Relevant steps were taken by management to address behaviours presented by the young people however, these were ineffective in bringing about change so a decision was made to discharge one of the young people.

Inspectors reviewed the policy on the use of restrictive procedures. From questionnaires and interviews, staff were aware of door and window alarms but only some referred to restraints as part of a restrictive practice used. There was no restrictive practice log in place and inspectors did not view any documents that outlined what restrictive practices were in use in the centre. Inspectors did not see any documentation relating to the process of reviewing restrictive practices by the team. Door alarms were discussed at child in care reviews and remained on the doors. The centre manager must ensure that there are relevant processes in place to log and review restrictive practices.

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Inspectors saw that there was an open culture promoted in the centre as both young people and staff were encouraged to raise concerns and to identify any areas they felt required improvement. Young people's meetings occurred weekly and the young people could contribute to have their voices heard. Two young people spoke with inspectors and inspectors reviewed two questionnaires. The young people gave feedback on using the young people meetings to discuss issues that affected them and they were also able to identify staff members they would speak to if they had any concerns. The young people were aware of the centre's complaints procedure. One young person had made a number of complaints about the amount of social workers that had been allocated over a short period of time. These complaints were sent to the relevant social worker and took time to be closed with no real outcome identified. Due to the changes in social worker, this held up the care plans that were in place for this young person which was around family reunification. The centre was not aware of 'Tell Us' through the Tusla website. Once informed of the service by inspectors, a complaint was made with the young person about the number of allocated social workers. Inspectors reviewed other complaints made by young people and found that the outcome of complaints were not detailed appropriately. The date the complaint

was closed was identified but no further information. Further details need to be included around the outcomes and if the young people are happy with the outcomes which will add to the overall learning and reflection of the complaints log.

There was evidence from the centre records of regular contact between the centre, social workers and family members. There was a collective approach in drawing up care and placement plans for young people. If family couldn't attend reviews, social workers informed the families of the outcome. Access was facilitated as frequently as possible which was hindered during Covid-19 for a period of time. Social workers interviewed provided positive feedback on the effective communication between them and the centre, however one social worker felt that recently since on-going peer to peer issues presented, there was a delay in receiving notifications about the incidents. Inspectors spoke with a guardian ad litem and received positive feedback regarding the supports the young person was receiving. Inspectors were informed of a formal system that was underway in the organisation where feedback was gathered from parents and social workers which the organisation intend to use to inform improvements in the service.

Inspectors reviewed the organisations policy on the notification and review of incidents. They were recorded in the appropriate logs; however, it was noted that some significant events required further clarity due to poor report writing. Staff were provided with further training when this was identified. Inspectors noted that there was information omitted from the reports regarding the duration and type of restraint used during an incident. Incidents were reported to social workers and guardian ad litem in a timely manner. The manager and regional manager had oversight of the incidents and gave in-depth feedback on the incidents for future learning for the staff team. Incidents were discussed at team meetings and during staff supervisions. SERG (significant event review group) occurred when a risk was identified and further interventions were discussed and fed back to the team. The most resent SERG was in relation to peer to peer bullying. Despite the resources of SERG and strategy meetings, the staff were unable to address the behaviours and the peer abuse continued resulting in one young person leaving the centre.

As a result of previous inspections within the organisation, it was identified that organisational learning was required in order to improve the standard of reviewing incidents. Inspectors found that this process was not happening for night time checks of the young people. Inspectors noted that relevant checks were not being completed appropriately on young people that had suicidal ideation and self-harm issues.

Inspectors noted that the documenting of the checks were not sufficiently recorded, were conflicting and on occasion did not identify who was carrying out the checks.

A serious incident occurred during the inspection period and inspectors were not notified of this by management despite being on site the following day. This showed a lack of transparency and oversight from management when dealing with the inspectors.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 3.2** **Standard 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that all staff are trained in a recognised model of behaviour management technique that includes both theory and practical aspects.
- The centre manager must ensure that young people are kept safe from peers and that staff respond appropriately to the challenging behaviour in a timely manner, using their recognised behaviour management techniques.
- The centre manager must review the pre-admission process and learnings from this specifically with regard to negative impact young people can have on each other.
- The centre manager must ensure that there are relevant processes in place to log and review restrictive practices.
- The centre manager must include information of 'Tell Us' for the young people to use if required.
- The centre manager must review the complaints log to include details of the outcomes.
- The registered provider must ensure that organisational learnings are implemented to ensure accurate information is collated in respect of night checks.

Regulation 5: Care Practice s and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The centre manager and the deputy were both experienced and qualified for their roles. Leadership was evident in the centre from reviewing the documentation and through the responses from the team during interviews. Staff reported that management were supportive, approachable and available to the staff team. Management comments were noted by inspectors on reports as clear and showing oversight of staff practices. This oversight highlighted areas of positive work from the team, areas where further development was required and actions that should have been taken by the team.

There were defined governance arrangements in place. Staff were aware of their roles and responsibilities and they were also aware of the organisational structure. Inspectors reviewed documents which outlined the delegation of tasks to other members of staff. The centre manager was identified as the person in charge and had oversight of the accountability for the service delivery in the centre. The regional manager and the centre manager carried out regular audits which inspectors reviewed and they showed that all areas were covered against the National Standards and included actions to be completed.

The organisation policies and procedures were updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA). There was a date of review attached. The policies sent to inspectors had no index. Inspectors noted that staff received refresher training on policies and procedures, some staff in late 2020 and others in early 2021.

The centre had a risk management framework in place which identified assessment and management of risk. Inspectors reviewed the risk management folder which contained a full outline of the statement of purpose and included a review date. These were developed and customised in each centre. Staff were to sign off on updates through the in-house document management system and completed training on risk

management during induction. The centre specific statement included information around the model of care, values and principals, management and staffing and the organisational structure. Included in this document was the centre risk register which included the risks, the immediate actions and the rating. It was not clear to inspectors how these risks were rated and how they were updated over time. The regional manager informed inspectors that there was a matrix in place for the risk rating and that the document was a live document which would change depending on the presenting behaviours of the young people. Inspectors noted that the centre risk register did not identify the risk attached to staff not being fully trained in a recognised behaviour management model due to Covid-19 restrictions causing a delay with completing the physical restraints training. The risk register did not identify the risk regarding young people and appropriate checks by staff at night time. Identifying any new risks in particular over 15 on the matrix was an agenda item on senior management meetings which enabled oversight across the organisation.

Inspectors reviewed the individual risk assessments belonging to the young people in conjunction with the centre risk register. Inspectors noted that two young people had fire setting as a high risk due to previous behaviours. Inspectors noted that the risk rating for fire setting went from an 8 to a 12 but it wasn't clear how or why this risk was increased. Inspectors reviewed reports which highlighted one young person stealing a lighter from a shop, trying to take lighters from staff and was aware of another young person's lighter in the office. Where risks are known there must be robust strategies in place to manage these and reviews in place to determine if the risk is being effectively managed.
The internal management structure in the centre consisted of one centre manager, a deputy manager and two child care leaders which was outlined in the centres purpose and function. There were people identified to contact in the case of an emergency and there was an on call system in place which the staff were aware of during interviews.

The centre manager and the regional manager confirmed that there were appropriate service level agreements in place with Tusla as the placing authority.

Staff spoke with inspectors about managing the centre with Covid-19 restrictions in place. Staff stated it was difficult at times in particular for the young people when they were isolating due to a positive case. Staff stated the young people struggled most with not seeing family during this time. Staff had access to all personal protective equipment and sanitiser as required. Staff had completed relevant Covid-19 training.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that robust pre admission risk assessments are in place to ensure the suitability of placements and consider the shared risks the young people have presented with.
- The centre manager must ensure that the risks are identified regarding deficits in training and input on the centre risk register.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found that workforce planning was undertaken with regards to oversight over staffing levels and capabilities. The centre manager had an understanding of the requirements around staffing, vetting and training. Inspectors noted from the senior management meetings that staffing was a recurring item on the agenda. This would include discussion around staffing needs, issues, succession planning, annual leave and sick leave. At the time of inspection there was eleven full time staff and four relief staff identified to the centre. Ten of these had a social care degree or a relevant equivalent while one full time staff and one relief staff did not hold a relevant qualification. The full time staff member had worked there three years and the relief staff for one year in the centre and were identified as trainees. The regional manager informed inspectors that the organisation offered support to the full time trainee staff

member to complete a relevant course but due to personal circumstances, the staff member could not commit to the course. There must be no trainee staff in the centre as the agency have neem informed of this on previous occasions but have continued to employ staff who are not qualified. Extra staffing had been approved in order to support the needs of a new young person.

The centre manager has been in position since the centre opened in 2018. There were five new staff that joined the team in the last year. There were three staff that left the centre since the last inspection due to a transfer, resigning and for personal reasons. Inspectors had access to one exit interview completed which highlighted poor communication between senior management and staff due to a change of the regional manager three times during the employment period.

Inspectors reviewed the rota and noted that during the month of October 2020, there were seven back to back shifts for staff. Inspectors were informed that the centre manager, two staff and one young person all tested positive for Covid at this time. On the rota, one staff member was identified as a trainee and had completed two back to back shifts. There must be sufficient time between shifts in order to ensure staffs health and safety was not compromised and to ensure the safeguarding of the young people was considered with staff working double shifts. The centre manager must ensure that the rota schedule allows for appropriate time off during shifts. It was noted that during January 2021 from the 4th until the 20th January, there was a reduction in staffing numbers from three to two per day. Inspectors were informed this was due to Covid-19 and to reduce the numbers of staff in the centre to curtail the possible spread of Covid-19. Inspectors were informed that there were two young people in the centre at the time and given their needs, two staff were sufficient. On the 21st January, there was a new admission and a third staff member was assigned per day. In reviewing the files during this period where there was two staff on shift, inspectors saw that plans continued to run as identified for both young people.

During interviews inspectors noted that more recently a young person was receiving two hourly checks during the night by staff that were on shift all day. Live night staff had not been assigned. There was no evidence of a robust risk assessment informing this as an adequate response. The risk to the staff's health and safety completing long hours of work and the impact to the safeguarding of the young people was not taken into account. An immediate response from the Alternative Care Inspection Management was requested from the centre to ensure that appropriate frequent checks were carried out and that live night staff were in place to complete this task.

The organisation had arrangements in place to help with staff retention which included training, counselling, employee assistance programme and healthcare packages. There was the availability of a relief panel which covered annual leave, sick leave and cover for any training needs.

There was an on call policy in place which outlined the procedures for the organisation. Staff were aware of this process when asked during interviews and in their questionnaire responses.

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

Inspectors reviewed the training and development documents relevant to the centre. It was evident that there was oversight of the training programme through the training manager within the organisation. Through reviewing the questionnaires and during the interviews, staff highlighted mandatory training and other relevant training they had completed. There was an in-house system where staff were informed of training required and between management and the training manager, staff would be made available through the rota to attend any such training. Staff had the opportunity to put forward any relevant training needs or extra training that may be beneficial to the team at team meetings and during supervisions. Staff files showed records of the induction process and what areas were completed. Mandatory training for staff included Children's First, fire safety, first aid and training in a recognised model of behaviour management. Both the centre manager and the regional manager had oversight of the training needs within the centre where they were notified of staff completing training or not arriving for training.

Inspectors reviewed the training needs analysis and noted that a number of dates were missing from the report in relation to staff completing the Care Framework and Child Protection online training. It was also noted that only one staff member had completed START training. There was no evidence to show that other staff had completed START, I Assist or self-harm training. These had been identified in risk documents as training completed by staff. Given the ongoing concerns of low mood, self-harm and suicidal ideation, training should be completed by staff as a matter of priority. Anti-ligature training had been completed by the staff.

Training needs were identified by staff during team meetings and supervisions. The team looked at the needs of the young people and identified any relevant training that

would support the team in their work. Epilepsy training was identified given the need of a young person, however there was a delay in the staff receiving this training which should have been completed prior to the young person's admission to ensure that the staff were appropriately trained to deal with the young person's medical needs.

Inspectors reviewed personnel files of three staff members. It was noted that when carrying out verbal reference checks for the staff, the questions did not include any relating to child protection which would be recommended given the nature of the work. One staff member's qualification had not been verified and inspectors could not see any efforts that were made to rectify this.

There was a formal induction policy in place which the staff were aware of when questioned. The induction programme took place over five days and included relevant training. An in-house induction also took place with staff members which was well documented.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 6.1** **Standard 6.4**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that all staff are appropriately qualified to work in the centre.
- The centre manager must ensure that the rota schedule allows for appropriate time off during shifts.
- The registered proprietor must ensure that staffing is in place to carry out live night checks when required, to ensure the health and safety of the staff is considered along with the impact on the safeguarding on the young people.
- The centre manager must ensure that relevant training the team required was made available promptly to ensure the young people's needs were being met.

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 an escalation process was in place to ensure that all young people have their up to date care plan. The centre manager must ensure placement plans have more emphasis on the young person's goals and achieving those goals in a timely manner.	All young people now have an up to date care plan, which allows for more detailed placement planning. Placement plan goals for young people have been focused on. Current young person's care plan was received on 14.05.21. The centre team completed Placement Plan training & Key working training on 7.7.21.	The 'Planning for a Young Person' Policy was updated in May 2021 to include the escalation process to be followed if a care plan has not been received. Placement Plan goals are reviewed with keyworkers & all team members in monthly supervisions. Quality Audits will ensure oversight of placement plan progress.
3	The centre manager must ensure that all staff are trained in a recognised model of behaviour management technique that includes both theory and practical aspects. The centre manager must ensure that young people are kept safe from peers	All staff received refresher training in physical aspects of TCI on 5th May 2021. Prior to any admission impact risk assessments are completed and sent to the	All elements of TCI training have resumed with refresher training scheduled for all Positive Care staff in line with policy. The Regional Manager will ensure that SERG reviews will occur as required with

	and that staff respond appropriately to the challenging behaviour in a timely manner, using their recognised behaviour management techniques. The centre manager must review the pre-admission process and learnings from this specifically with regard to negative impact young people can have on each other. The centre manager must ensure that there are relevant processes in place to log and review restrictive practices. The centre manager must include information of 'Tell Us' for the young people to use if required.	placing Social Worker via the NPPT for consideration. These risk assessments are also forwarded to the Social Workers of young people currently in placement. The Statement of Purpose risk register now includes the risk of restrictive practice. Restrictive practice is also reviewed on individual risk management plans where restrictions are necessary as a risk reduction measure. TCI restraints are logged in a hard copy register. All young people received the Tell Us information 25th March 2021. Tell Us Policy has also been reviewed with the centre team on 18.8.21 through Team Meeting.	input from TCI trainers and the Clinical Department. This will ensure oversight of staff responses to challenging behaviour. Centre Manager will ensure that all stakeholders are consulted in relation to the potential impact young people can have on each other. The impact risk assessment will be forwarded to all social workers for consideration prior to any future admission to the centre proceeding. The use of restrictive practice is now reviewed as part of weekly management meetings, and monthly service governance reports. The use of restrictive practice as part of risk reduction management is reviewed with placing Social Workers monthly and in CICRs. Centre Manager will ensure that young people will be kept informed of the " Tell Us" process through scheduled keyworking sessions.

	The centre manager must review the complaints log to include details of the outcomes. The registered provider must ensure that organisational learnings are implemented to ensure accurate information is collated in respect of night checks.	Complaints have been reviewed on 13th May 2021 to include all details of outcomes. The recording of checks on young people if required is recorded on a section of the daily logs with instruction to accurately record detailed information re times of checks both day and night.	The register has been reviewed to ensure that the outcomes are fully noted. All registers are reviewed for accuracy as part of the auditing process. Oversight of this process will be maintained by Centre Management, Regional Manager and Quality Auditors.
5	The centre manager must ensure that robust pre admission risk assessments are in place to ensure the suitability of placements and consider the shared risks the young people have presented with. The centre manager must ensure that the risks are identified regarding deficits in training and input on the centre risk register.	Prior to any admission impact risk assessments are completed and sent to the placing Social Worker via the NPPT for consideration. These risk assessments are also forwarded to the Social Workers of young people currently in placement for their input. All staff members are currently trained in mandatory training needs including physical TCI refresher courses.	Centre Manager will ensure that all stakeholders are consulted in relation to the potential impact young people can have on each other. The impact risk assessment will be forwarded to all social workers for consideration prior to any future admission to the centre proceeding. If any training deficit occurs, this will be detailed on the centre risk register as directed.
6	The centre manager must ensure that all staff are appropriately qualified to work in the centre.	An Educational Assistance fund is available and continues to be available and offered to all staff who are not qualified to an appropriate level.	Only appropriately qualified staff will be contracted to the Centre.

	The centre manager must ensure that the rota schedule allows for appropriate time off during shifts.	Back to back shifts will not be rostered and the roster in place will allow for appropriate time off between shifts in line with Working Time Act guidelines.	Staffing reports are circulated daily to senior management to ensure staffing compliance with no double shifts rostered and the organisation will endeavour to ensure that these do not take place.
	The registered proprietor must ensure that staffing is in place to carry out live night checks when required, to ensure the health and safety of the staff is considered along with the impact on the safeguarding on the young people.	An alternative roster has been developed which will be implemented should live night checks be required. This roster will provide for a dedicated staff member to complete these checks**.**	Should live night checks be required an alternative roster will be implemented for the duration of the period with a dedicated staff member working an 8-hour night shift to complete these checks.
	The centre manager must ensure that relevant training the team required was made available promptly to ensure the young people's needs were being met.	The delay in providing the specific training noted to meet the young person's needs was due to covid restrictions in place. The centre management will provide all relevant external training as soon as it can be facilitated.	Any non- mandatory training requirements will be provided to the staff team if required in a timely manner.