An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 002

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Solis MMC Children's Services**
Registered Capacity:	**Three Young People**
Type of Inspection:	**Announced**
Date of inspection:	**04th, 05th and 06th April 2022**
Registration Status:	**Registered from 05th December 2020 to 05th December 2023**
Inspection Team:	**Lorna Wogan** **Sinead Tierney**
Date Report Issued:	**28th June 2022**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 05th of December 2014. 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 without attached conditions from the 05th of December 2020 to the 05th of December 2023.

The centre was registered to provide emergency respite accommodation to three young people both boys and girls aged between 12 and 17 years. The centre operated three categories of placements. Firstly, for young people whose care placement had broken down and they required an emergency bridging placement for a maximum period of seven days. Secondly, a placement for up to twenty-one days for young people in an emergency who can return home or to their previous placement. Thirdly, emergency placements referred through the Tusla social work out-of-hours service. The relationship approach model of care was based on Erik K. Laursen's Seven Habits of Reclaiming Relationships. The model is based on the understanding that caring relationships are key to the development of resilience. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 13th May 2022 and to the relevant social work departments on the 13th May 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 27th May 2022. This was deemed not to be satisfactory and the inspection service requested additional information that was forwarded to the inspectors on 02nd June 2022.

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: 002 without attached conditions from the 05th December 2020 to the 05th December 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The emergency residential service was located in an older building and the managers, staff and social workers interviewed by the inspectors acknowledged the limitations of the premises in this regard. The managers informed the inspectors that initial discussions had commenced in relation to relocation of the service to a more modern premises. There was one bathroom in the premises shared by the young people which supported the rationale for moving premises. During the on-site inspection, inspectors found the premises were maintained to a sufficient standard. Good efforts were made to make the centre feel more homely. There was evidence that the centre manager was driving improvements within the environment, ensuring the premises were safe and that maintenance issues were attended to in a prompt manner. There was evidence the young people living in the centre were consulted and involved when furniture and soft furnishings were purchased for the centre. The inspectors found the outside recreational facilities could be improved for the young people with the addition of football goals and the purchase of a new basketball hoop to replace the one that was broken on site. Both social workers interviewed suggested that the external entrance area could be improved to make it more welcoming in appearance.

The young people had their own bedroom and they told the inspectors their privacy was respected. On inspection of the young people's bedrooms, they were provided with storage baskets in cubed storage units however these did not appear to be suitable or effective for the young people to organise their clothes and personal possessions. One of the bedrooms viewed by the inspectors was particularly chaotic in appearance and there was no evidence of efforts to personalise the bedroom space with the young person. Following interviews with staff and managers there appeared to be a practice in place that staff knock on the young people's door to check on them

verbally but staff in general did not enter the young people's bedrooms unless the young people did not respond to them and they were concerned about their wellbeing. The inspectors became aware that one young person regularly covered the smoke detector in their bedroom to prevent staff being alerted to them smoking in the room. Additionally, since the last inspection a fire incident had occurred in this young person's bedroom. The inspectors found that additional safety measures were put in place following the fire however there were on-going risks in relation to fire safety in the young person's bedroom. The centre manager must ensure that room checks by staff form part of the daily fire safety checks.

The centre had written confirmation from a certified engineer that all statutory requirements relating to fire safety and building control had been complied with. The centre maintained a fire register on site which was reviewed by the inspectors. The fire safety statement and the fire evacuation plan were displayed in the centre. The fire safety statement referenced the former national standards 2001 and must be updated to reflect the current national standards. All the relevant internal fire safety checks and fire drills were recorded on the register. All young people who had been admitted to the centre over the past twelve months were recorded on the fire register as having completed a drill. One young person interviewed by the inspectors stated they had not participated in a fire drill or talked through the fire evacuation procedures with staff however the inspectors were unable to verify this information. The centre manager must check the accuracy of this record and ensure the young person has participated in a fire drill exercise. The fire safety representative must also ensure that at least one fire drill annually is carried out under the cover of darkness. The annual maintenance of the fire extinguishers was not evidenced on the centre's fire register. The fire safety representative must ensure the maintenance engineer signs this section of the fire register to evidence the service of equipment or attach the maintenance certificate to the relevant section. Additionally, the fire register did not evidence a record of fire safety training undertaken by staff in 2021 or 2022. Following a review of the staff training records the inspectors found that fire safety, first aid and manual handling training was not up to date for all staff. The centre manager must ensure the deficits identified by the inspectors on the centre's fire register are rectified and that mandatory training for all staff is completed and kept up to date.

The centre had a written safety statement that was centre specific and identified the centre's health and safety representative. On review of the statement the inspectors found there was a strong focus on pre-admission risk assessments and the inspectors recommend that the other environmental risks are equally weighted as part of the

statement development. The inspector's reviewed some site-specific risk assessments. The centre must complete, at least annually, a re-assessment of hazards and risks associated with the premises and the safety statement itself must identify the staff who are fully qualified as First Aid Responders as required under health and safety legislation. The inspectors recommend that all site-specific risk assessments are located in the one folder and that there is clarity around the status of the risk assessments as some site-specific risk assessments were classified by staff as 'open' and others were classified as 'live' and were thus stored in a separate folder. The centre manager should review how all site-specific risks are classified, located and monitored in the centre. Health and safety checks on the premises were completed on a monthly basis by staff and covered all areas relating to safety of the premises with comments and actions required identified appropriately.

The centre maintained a record of all accidents and injuries that occurred and these records were maintained on a centre register and in the young person's care file with clear procedures in place for reporting such accidents and injuries. However, the inspectors found that the accident register for 2021 was not up to date. The last entry on the register was in August 2021 yet there were eight additional incidents after this date. The centre manager must maintain oversight of the accident log and ensure it is updated to reflect all accidents that have occurred since August 2021. First aid boxes were located in the staff office and in the centre vehicles and there was a system in place to ensure stock levels were checked and supplies replaced when used.

The centre vehicles were found to be clean, roadworthy, regularly serviced, insured, taxed and driven by staff who were legally licenced to drive the vehicles. The centre recorded all vehicle maintenance checks and repairs and there were systems in place to undertake daily cleaning and checks on the centre vehicles.

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

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

Actions required

- The centre manager must ensure the outside recreational facilities are improved for the young people with the addition of football goals and the purchase of a new basketball hoop to replace the one that was broken on site.
- The centre manager must ensure that bedroom checks by staff form part of the daily fire safety checks.
- The centre manager must ensure the fire safety statement is updated to reflect the current National Standards for Children's Residential Centres, 2018 (HIQA).
- The centre manager must ensure the deficits identified by the inspectors on the centres fire register are rectified.
- The centre manager must ensure that mandatory training in fire safety, first aid and manual handling for all staff is completed and kept up to date.
- The centre manager must check the accuracy of the fire drill records and be assured that each young person has participated in a fire drill exercise. The fire safety representative must also ensure that at least one fire drill annually is carried out under the cover of darkness.
- The centre manager must complete, at least annually, a re-assessment of hazards and risks associated with the premises and the date of review must be reflected on the safety statement and on the risk assessments.
- The centre manager must ensure that the safety statement identifies the staff members who are fully qualified as First Aid Responders as required under health and safety legislation.

- The centre manager must maintain oversight of the accident log and ensure it is updated to reflect all accidents that have occurred since August 2021.

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

Theme 3: Safe Care and Support

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

There were policies in place to support the management of behaviour. However, the centre policy on behaviour management did not outline how staff promote a positive approach to the management of behaviour that challenges. Staff in interview demonstrated to the inspectors how they used their relationship with the child and applied elements of the model of care as well as listening to their views, teaching them, giving praise and positive reinforcement to promote positive behaviour. Inspectors found that staff did not rely on sanctions to manage behaviour and this was confirmed by the social workers. There was evidence that staff members had undertaken individual key working with the young people to support them to develop an understanding of their presenting behaviours. As the service provides care in an emergency situation, the pre-admission risk assessment was the main piece of information staff used initially to manage and respond to behaviour that challenges. The inspectors saw evidence of this information being added to over time in particular with the risk assessments for young people. These assessments were up to date and contained relevant information.

There were behaviour support plans developed for the young people that were up to date and subject to regular review. The inspectors found that the absence management plans on file were not completed in full with curfews and emergency contacts not identified in some instances. The risk assessment and safety plan specific to each young person's unauthorised absence from the centre was not completed on the absence management plans. Additionally, some of the known behaviours set out in behaviour management section of the behaviour support plans for young people were not included or considered in the context of absences or being missing from care. The inspectors found that the individual crisis support plans could be further improved to include the use of specific aspects of the relational model and TCI de-escalation techniques that worked most effectively at each stage from baseline behaviour to the outburst stage.

There was a behaviour management system in place and the inspectors found that in 2021 some staff members had not received core training in this behaviour management system, refreshers were not undertaken within the recommended timeframes and refresher training in physical restraint interventions were not completed as required. There was no risk assessment on file to address the risk associated with the lack of appropriate training for staff despite the fact that physical restraint interventions were identified on the young people's behaviour support plans. The individual crisis management plan for one of the young people indicated that physical restraint was an agreed intervention strategy however inspectors recommend that this intervention is reviewed by the manager, social worker and staff team to assess the safety and suitability of the intervention for this young person in particular. The inspectors found that there were no physical restraint interventions employed by staff since the last inspection.

There were a number of practices of concern for the inspectors that came to light in the course of the inspection. Firstly, a review of significant event notifications and other centre records evidenced that young people were required to undertake a self-search on return to the centre from any unsupervised time away from the centre. This is not in line with the centre policy on physical searches which outlined that such searches should not be a daily or routine procedure and must be risk assessed each day to assess if they were required and that a record was maintained to outline the reasons behind the decision to search. The policy stated that practice should never take place unless warranted. Records reviewed by the inspectors evidenced that a practice of self-search was often the initial response to young people on their return to the centre and there was no assessment on the care records of its requirement. The allocated social worker for one young person where this practice was in place was not aware the practice. The centre manager must ensure the practice of self-search on return to the centre is only carried out where there is an identified potential risk and in line with centre policy. The implementation of this practice must be discussed with the allocated social worker.

Secondly the inspectors found there were inconsistencies in knowledge and in practice around the implementation of the centre's policy in relation to young people missing from care. Following interviews with managers and staff the inspectors found there was lack of clarity and different interpretations by staff and managers of the policy in relation to the requirement for young person to present to the nearest Garda station for collection by staff when returning to the centre following a period of absence or being reported as missing form care. The centre management must have absolute clarity on how this policy is implemented in the centre so there can be no

ambiguity for staff in relation to the practice. There may be particular circumstances where the practice of directing the young people to the nearest Garda station is necessary however it must be based on the safety of the young person or risks to staff and outlined in the young person's absence management plan. Where this practice is implemented, the social worker must be informed.

The centre maintained a register of all significant events. The inspectors found the recording system was cumbersome in its layout and was not an effective system to track patterns and tends in relation to significant events that occurred in the centre. There were some identified inaccuracies in the referencing tracking system and the identified nature/category of event in many cases was vague sometimes just citing that the young person moved away from baseline behaviour. There was an incident in August 2021 where a centre vehicle was stolen and there was no reference in classification of event to a car being stolen. The centre manager must review the register to ensure it is fit for purpose in terms of tracking patterns and trends in relation to significant events.

The inspectors found there were two separate incidents in 2021 where young people gained access to car keys and drove the centre vehicle from the centre. There was no evidence in the centre records that either of these two serious incidents were investigated internally by the centre manager who was in post at the time or by the service manager. There was no evidence of a full review of the incidents at the team meetings or of any identified learning outcomes of safety strategies in place to minimise the likelihood of such an event occurring again. The inspectors were unable to review the significant event reports of these incidents as the records were returned to Tusla for archiving within six weeks of the young person's discharge. The service manager must ensure the centre retains certain records for a period of time to ensure they can be included for review within the significant event review meetings.

The inspectors found that the review of significant events by the centre management was not sufficient or in line with the centre policy. There was evidence that significant events were discussed at local level at team meeting and the centre manager was making efforts to embed this into practice at the team meetings. There was, however, a gap in the external oversight of significant events through the significant event review group (SERG) process. The inspectors reviewed records that recommended the SERG review process should be incorporated into the regional managers meetings however there was no evidence this had occurred in practice. Given the absence of any SERG meetings the oversight of critical events by senior management was not evident.

The inspectors reviewed several significant event reports. There was evidence the centre manager reviewed these reports and recorded summary comments on the event. The inspectors recommend that a more detailed analysis of the event is undertaken by the manager to assess whether staff interventions reduced risk and increased safety. The review could also include what worked well and what interventions may need to be reviewed, whether interventions were in line with the individual crisis support plan and centre policies and if there was any identified learning from the management of the incident. Following the review of significant event reports the inspectors also found that staff responses to the young people in crisis did not always reflect responses that were in line with the centre's model of care. The inspectors recommend that the service manager facilitates specific training for the team in attachment based and trauma informed approaches to working with young people to further develop the skills within the team to understand and respond to behaviour that challenges.

External quality audits were completed in line with the centre policy. Five quality audits were completed in 2021 and one to date in 2022. Audit reports were completed in a timely manner, were comprehensive with clear recommendations. There was evidence that significant events and restrictive practices were reviewed and the staff's knowledge of policies and procedures was tested when the auditor was on site. Actions plans were completed for each audit and they were discussed and reviewed at team meetings, house management meetings and in the centre managers supervision. The service manager must sign off on the audit action plan to evidence their oversight of the audit process.

The centre had a register in place to record restrictive practices. Restrictive practices that were implemented on a once off basis were clearly recorded. Some restrictive practices were used on an ongoing basis and as such do not need to be recorded daily once there is evidence of their review within a set timeframe. There was evidence on the care records that restrictive practices specific to one of the young people were at the direction of the allocated social worker. However, for some of the other restrictive practices there was no evidence on the register of consultation and agreement with the social worker in relation to the practice. The review of restrictive practices in the team meetings must evidence more detail in relation to the outcome of the review of the practices for example if they are still required or can be minimised.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The service manager must ensure the centre policy on behaviour management outlines how staff promote a positive approach to the management of behaviour that challenges.
- The centre manager must undertake a more detailed analysis of the significant event and ensure learning from the event is identified.
- The centre manager must ensure that the absence management plan is completed in full and the risk assessment and safety plan specific to each young person's unauthorised absence from the centre is set out on the young people's absence management plans.
- The service manager must ensure that all staff are fully trained in the behaviour management system and that refresher training requirements are in compliance with the programme requirements for training.
- The centre manager must ensure the practice of self-search on return to the centre is only carried out where there is a potential risk and in line with centre policy. This practice must be discussed and agreed with the allocated social worker.
- The centre manager and the service manager must review the procedures in place in relation to young people returning to the centre following unauthorised absences.
- The service manager must ensure the centre retains certain records for a period of time to ensure they can be included for review in significant review meetings.
- The service manager must ensure that SERG meetings are undertaken in line with centre policy and that where serious incidents occur in the centre there is a full and complete investigation of the event evidenced on the centre records.

- The centre manager must review the significant event register to ensure it is fit for purpose in terms of tracking patterns and trends in relation to significant events.
- The service manager must sign off on the audit action plan to evidence their oversight of the audit process.
- The centre manager must ensure that the restrictive practice register records that there was consultation with the social worker to implement the practice and the team meeting records must provide more detail in relation to the outcome of the review of restrictive practices.

Regulation 5: Care Practices 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 was in post for a period of five months and had previously worked in the centre for a number of years. They were the identified person in charge within the centre and were based at the centre from Monday to Friday. The inspectors found they were establishing themselves in the leadership role and this was recognised by the quality assurance officer in their previous two external quality audits. There was evidence of oversight of records by the centre manager and an understanding of the management role and responsibilities in relation to governance and oversight. The centre manager completed a two-day induction with the service manager prior to taking up the role. At the time of the inspection the centre manager was completing the final term of a degree programme and when completed will be appropriately qualified to be in post.

Staff interviewed by the inspectors stated the manager was supportive, accessible and had a positive approach with young people. The young people interviewed knew who was in charge of running the centre. One young person who resided in the centre for a number of months identified the centre manager as one of a number of key staff with whom they had a positive relationship. This was also confirmed by the young person's social worker.

The centre manager was supported by a part-time deputy manager who was an experienced member of the team. The inspectors saw evidence of their oversight of records, tracking of child protection concerns and of induction training undertaken by them with newly appointed staff members.

The internal management structure comprised of the centre manager, a part time deputy manager, a shift team manager and one social care leader. Individual work undertaken by the team leaders evidenced the positive support provided to the young people in relation to their behaviours and presentation. The centre records also evidenced the support and guidance internal leaders provided to the social care team in their work.

The inspectors found no written record of delegated duties. The centre manager must ensure that where they delegate some or all of their duties to one or more appropriately qualified staff members a written record is maintained of when, and to who such duties have been delegated and key decisions made.

There were a number of systems in place for the oversight of practice and to assess compliance with regulations, the national standards and adherence to centre policies and procedures. The centre manager completed monthly governance reports which recorded data and information on various aspects of centre activities that was forwarded to the service manager and head office for oversight. The inspectors advise that the service manager provides evidence of oversight or sign off on these audits completed by the centre manager as part of their governance role. The centre's governance folder also contained the external quality assurance audit reports, monthly managers house meetings and senior management meeting. The records showed that only one senior management meeting was undertaken in June 2021 however at the time of the inspection the service manager informed the inspectors that the senior management meeting forum had recommenced.

The role of the service manager was to provide external leadership, governance and management of the centre. The inspectors found that the external governance and oversight of the centre by the service manager was not sufficiently robust and required improvement. The inspectors were informed that the centre manager and the service manager met formally on a weekly basis in the services head office however records of these meetings were not maintained to evidence discussions or decisions in relation to the management and operation of the service. The service manager visits to the centre were not in line with the timeframes outlined in the centre policy document and where visits were undertaken there was no documented

evidence of the purpose/outcome of the visits. A quality audit report highlighted that for a period of months in 2021 the centre was 'left vulnerable and there were gaps in quality' due to the absence of managers and staff due to sick leave and annual leave. There was no evidence on the records of any additional support or oversight of the centre from the external manager during this time or that any actions had been taken by the service manager following this finding. Equally, there was no evidence of the service manager's attendance at team meetings in the past six months. Regional management meetings had recommenced in March 2021 and four regional meetings were chaired by the service manager up to November 2021 in line with the centre policy however no regional management meetings had taken place since November 2021. The service manager must ensure that they carry out their role as set out in the centre's policy and procedures document to ensure there is robust external governance and management of the centre and its operations.

The service manager had responsibility for supervising the centre manager. The inspectors found that the centre manager had received formal monthly supervision in line with the centre policy and the supervision records were reviewed by the inspectors. There was evidence of discussions in supervision in relation to audit outcomes, the managers role and responsibilities, house maintenance issues, staff recruitment and staff training requirements.

The centre was contracted to provide the service by Tusla's National Private Placement Team (NPPT) and the proprietor, and the service manager met regularly with the NPPT to review the services provided and the children's progress.

Operational policies and procedures were developed, reviewed and updated in line with regulatory requirements. There was evidence the quality assurance auditor periodically tested staff knowledge about policies and procedures as part of the auditing process. There was evidence of good oversight of the policy supervision training for new staff members at the internal managers meetings. On review of six team meeting records the inspectors did not find evidence that centre policies were discussed at team level. The centre manager must provide a forum for staff to review and revise centre policies particularly the policies that relate to current practice for example physical searches of young people to ensure the practice is in line with the approved written policy.

The risk management framework in place was fit for purpose and supported the identification, assessments and management of behaviours in particular. There was a corporate register in place. Risk assessments completed were comprehensive, with

appropriate control measures to reduce and manage risk and evidence of review. The inspectors identified a number of risks that were not subject to a risk assessment. The absence of core, refresher and physical intervention training in the centre's behaviour management system for some staff members had not been assessed. Additionally risks associated with the young people's behaviour in relation to fire safety and mobile phone safety did not have appropriate safeguarding practices in place. The service manager must ensure all risks are appropriately identified and that the risk management framework is applied consistently across all areas of risk management. Social workers interviewed confirmed risk formed part of ongoing discussions with the centre manager and they were satisfied with how the centre was managing the risks related to young people on a day-to-day basis.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that where they delegate some or all of their duties to one or more appropriately qualified staff members a written record is maintained of when, and to who such duties have been delegated and key decisions made.
- The service manager must ensure that they carry out their role as set out in the centres policy and procedures document to ensure there is robust external governance and management of the centre and its operations.
- The centre manager must provide a forum for staff to review and revise specific centre policies particularly the policies that relate to current practice to ensure that staff practice is in line with the approved written policy.
- The service manager must ensure all risks are appropriately identified and that the risk management framework is applied consistently across all areas of risk management.

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.

Following management and staff interviews, a review of the centre records and the on-site inspection visit the inspectors included standard 6.1 in this inspection activity to address issues that arose in relation to staffing within the centre. The previous inspection of this centre in June 2021 found there was an over-reliance on agency staff, relief staff and staff to work overtime to cover the roster that required, two sleep-over staff, one day shift up to 11pm and one live night staff. Following a review of the staffing information sheet, rosters, other relevant records it was evident that staffing was an ongoing challenge to achieve full cover during the day and a waking staff every night. There were two relief staff members identified on the staffing information sheet submitted to the inspectors however at the time of the inspection these staff members had not yet commenced work in the centre and staff from across the organisation along with agency staff were used to provide relief cover since the last inspection. The staff information form submitted to the inspectors indicated there were nine staff members on the team, however one recently appointed staff member was on leave for an extended period and another staff member was the dedicated waking night staff. The inspectors found there was a short period between January and March 2022, prior to a new staff member commencing employment, where the number of core staff members fell to 7 which was below the minimum staff requirements of eight staff on a team to meet the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article: 7 Staffing. During the inspection the inspectors found one staff member had completed a 24-hour sleep-over shift and was remaining on duty to cover a day shift until 11pm thereby completing a 36-hour shift. Additionally, the inspectors found there were significant periods of time where there were no live night staff and other periods where the dedicated night staff member completed an excessive number of live nights with an inadequate number of days off to allow for sufficient rest periods.

Following interviews with staff and managers the inspectors found there were inconsistencies in the staff practice when there was no waking staff on duty. The inspectors were informed by staff that when there is no night staff the sleep over staff inform the young people of this and remind them to call the sleep-over staff should

they required assistance during the night, however the centre manager and the service manager were of the understanding that the sleep-over staff split the waking hours between them. A young person interviewed stated to the inspector that when they awoke the night prior to the on-site inspection and there was no night staff on duty as the night station was locked with no staff member around when they got up during the night. The night log report for that night was reviewed by the inspectors and the record indicated hourly night checks were completed throughout the night and that the young people were asleep and did not get up during the night. It is imperative that centre records are an accurate reflection of the practice. The centre manager and the service manager must provide clarity in relation to the arrangements in place to ensure the young people are safeguarded throughout the night when situations arise where there is no dedicated night staff on duty. The expectations of management in relation to the supervision of the young people by staff on sleep over duty must be relayed to staff and be risk assessed.

The ongoing demands on managers to secure staff to cover shifts across the roster was time consuming for the manager and limited their time to attend to the day-to-day management tasks and responsibilities. The service manager must ensure that there is absolute clarity in relation to the appropriate numbers of staff required on the core team with regard to the number and the needs of the young people, the centres statement of purpose and the contracting arrangements with the funding body. The service manager must also ensure the centres statement of purpose sets out the management and staff numbers employed in the residential centre.

Following a review of staff personnel files provided to the inspectors it was found that staff recruitment was not in compliance with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020). In this instance inspectors found that a staff member was recruited since the last inspection and subsequent to the memo being issued to the provider, that did not hold the required qualification. This issue was raised at the last inspection following the employment of another staff member who did not meet the qualification requirements. The inspectors also found that the reference checks for another recently recruited staff member were not in line with reference vetting requirements. A written reference from their most recent employer was not secured even though they had worked for a number of years with this employer. The centre manager must ensure that a written reference from the most recent employer is secured on file as a matter of priority to ensure robust vetting procedures are in place and reference checks on staff are in line with vetting requirements.

There was evidence that staff retention strategies were discussed at regional management level within the organisation and there were arrangements in place to promote staff retention. The review of supervision files evidenced that annual performance reviews with staff had not been undertaken in line with centre policy. The centre manager and the service manager must set out a plan to ensure all staff receive a performance review by the end of the year.

The inspectors were informed that the centre manager provided on-call support to the service outside of office hours and at weekends throughout the year. Staff confirmed that when the centre manager was on annual leave the service manager provided on-call support to the centre. The inspectors and the service manager were of the view it was not a sustainable arrangement for the centre manager to be on call at all times. Furthermore, both the centre manager and service manager lived a considerable distance from the centre therefore could only provide telephone support to staff in a crisis situation as it would take a number of hours before they could be present on site were an emergency to arise. The service manager must ensure there are suitable on-call arrangements in place to ensure the manager has sufficient breaks from the on-call support service and that in an emergency a senior staff member can be present on-site in a timely manner.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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

Actions required

- The centre manager and the service manager must provide clarity in relation to the arrangements in place to ensure the young people are safeguarded throughout the night when there is no dedicated night staff on duty. The expectations of management in relation to the supervision of the young people by staff on sleep-over duty must be relayed to staff and be risk assessed.

- The service manager must ensure that there is absolute clarity in relation to the appropriate numbers of staff required on the core team with regard to the number and the needs of the young people, the centres statement of purpose and the contracting arrangements with the funding body. The service manager must also ensure the centres statement of purpose sets out the management and staff employed in the residential centre.
- The service manager must ensure that staff recruitment is compliant with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).
- The centre manager must ensure that a written reference from the most recent employer is secured on file as a matter of priority to ensure robust vetting procedures are in place and reference checks on staff are in line with vetting requirements.
- The centre manager and the service manager must set out a plan to ensure all staff receive a performance review by the end of the year.
- The service manager must ensure there are suitable on-call arrangements in place to ensure the manager has sufficient breaks from the on-call support service and that in an emergency a senior staff member can be present on-site in a timely manner.

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 the outside recreational facilities are improved for the young people with the addition of football goals and the purchase of a new basketball hoop to replace the one that was broken on site.	Replacement football nets and basketball net have now been purchased and in place. A consultation process is under way with residents to ascertain consumer choice and this will be a feature in terms of weekly activity planning.	Team Meetings will contain a standing Agenda Item titled Repairs and Renewals and recreational equipment will be discussed. Purchases will be authorised by the Centre Manager (€75) from weekly living expenses or a requisition approved by the Service Director.
	The centre manager must ensure that bedroom checks by staff form part of the daily fire safety checks.	The Daily Cleaning Schedule / Fire Safety Checklist will reflect bedroom checks requiring access. This will be explained to the young person and Social Worker, from a health & safety perspective, at the admission meeting for their consent.	This will be a delegated verification responsibility for Team Leaders. Daily Cleaning / Fire Safety Schedules will be circulated along with the Daily Update and Vehicle Checklist to CEO, Service Director and Centre Manager.
	The centre manager must ensure the fire safety statement is updated to reflect the current National Standards for Children's Residential Centres, 2018 (HIQA).	The Fire Safety Statement has been updated and in place.	Assurance that Fire Safety Statement is current will be the responsibility of the Centre Manager. Solis MMC Children's Services are in the process of Corporate Compliance Reports (CCR) for each Centre

			to be returned to the Compliance Officer at HQ. Fire Safety monitoring and compliance will be an integral heading. This will be verified through Audits on a quarterly basis.
	The centre manager must ensure the deficits identified by the inspectors on the centres fire register are rectified.	All deficits have now been addressed and verified by the Service Director.	The monthly CCR will confirm compliance with the Fire Register as verified by the Centre Manager. This will be confirmed through on-site quarterly audit.
	The centre manager must ensure that mandatory training in fire safety, first aid and manual handling for all staff is completed and kept up to date.	Training has been booked as follows. 19th May 2022: Fire Safety Training 16th June FAR training 30th June Manual Handling	The Training Officer will monitor the training needs analysis and organise training accordingly in conjunction with Centre Manager. The Centre Manager will complete the MMC HR Department's CCR on a quarterly basis verifying up to date training for staff. The Service Director will be advised of deficits for immediate address.

	The centre manager must check the accuracy of the fire drill records and be assured that each young person has participated in a fire drill exercise. The fire safety representative must also ensure that at least one fire drill annually is carried out under the cover of darkness.	Following review of the fire book and conversations with the staff team it was found that the recording in the fire book was accurate. Fire drills for each young person is a mandatory requirement and will be adhered to accordingly. The Admission Pro Forma process will be explicit in terms of advising the young person and Social Worker of this health & safety essential. The staff team will ensure that fire drills are completed with each new admission to the centre. A night-time/darkness fire drill was conducted at 10.30pm on the 18.05.2022.	The Admission Pro Forma will record that compliance was sought and agreed upon by SW and YP. The said form will record the timetable for the initial planned exercise, and this will be verified in the Daily Log. This will be a delegated responsibility for Team Leaders and verified by Centre Manager / Deputy.
	The centre manager must complete, at least annually, a re-assessment of hazards and risks associated with the premises and the date of review must be reflected on the safety statement and on the risk assessments.	MMC Children's Services will commission an architect with fire safety expertise to undertake a six-monthly assessment with the Centre Manager.	The commissioning of an architect will be a corporate responsibly and the said architect will report, et al, to the Service Director. The Centre Manager will ensure that all recommendations are adhered to and this will be verified by the Service Director and quarterly site audit visits.
	The centre manager must ensure that the safety statement identifies the staff members who are fully qualified as First Aid Responders as required under	The Safety Statement has been updated with fully qualified First Aid Responders added and this will be added to as more responders are trained.	Verification that the safety statement is current will form part of the monthly CCR and will be verified through quarterly audit site visits.

	health and safety legislation. The centre manager must maintain oversight of the accident log and ensure it is updated to reflect all incidents that have occurred since August 2021.	The Accident Logbook has been updated to reflect accidents since August 2021. This critical recording has a direct correlation with Accident Report Forms which are sent to HQ for transference to our Insurance Company Broker.	The CCR will have a pro forma section to verify that Accident Report Forms as sent to HQ, correlate the Centre's accident logbook. Reporting accidents to HQ is not discretionary and the Service Director will verify sight of same through site visits and this will also be verified through quarterly audit.
3	The service manager must ensure the centre policy on behaviour management outlines how staff promote a positive approach to the management of behaviour that challenges.	The Centre Manager and Service Director will undertake a review of the behaviour management policy. Time Scale – Completion by: 21st June 2022	The Behaviour Policy will be reviewed and staff encouraged to adopt a positive approach to challenging behaviour. Negotiation with NPPT is critical in attempting to return to the parameters of the statement of Purpose & Function and we need to advise our staff of our attempts in this regard. Ongoing motivation of staff coupled with creative diversionary programmes will be reinforced by the Centre Manager.

	The centre manager must undertake a more detailed analysis of the significant event and ensure learning from the event is identified.	The Centre Manager will provide a much more detailed analysis of SEN's from a team learning prospective for helping manage the young person behaviours while in residence. Such analysis may also inform the referring social worker in terms of the type and capacity required for an onward placement centre. SEN review and analysis will also be a standing agenda item at team meetings. Time Scale – Completion by: 21st June 2022	The Service Director will, during governance visits, have oversight of the SEN's and advise on the content of the analysis from a learning perspective for staff. SEN review and analysis will also be an agenda item on regional operational meetings.
	The centre manager must ensure that the absence management plan is completed in full and the risk assessment and safety plan specific to each young person's unauthorised absence from the centre is set out on the young people's absence management plans.	The absence management policy will be reviewed, amended as appropriate for immediate implementation. This review will be undertaken by the Centre Manager and the Service Director. Time Scale – Completion by: 7th June 2022	The Absence Management Plan is essential as a reference for staff and will be reviewed for immediate implementation. The Service Director will have sight of absence management plans through governance visits as will the audit processes.
	The service manager must ensure that all staff are fully trained in the behaviour management system and	The Service Manager will organise refresher training accentuating the need for balanced intervention with an emphasis on	Refresher training in behaviour management will be completed twice yearly and will be noted on the training schedule

	that refresher training requirements are in compliance with the programme requirements for training.	recognising and reinforcing the positive behaviour. Time Scale – Completion by: 9th June 2022	drawn up by the Training Officer. This will be verified on the CCR report to Headquarters.
	The centre manager must ensure the practice of self-search on return to the centre is only carried out where there is a potential risk and in line with centre policy. This practice must be discussed and agreed with the allocated social worker.	The Service Director will undertake an immediate review of the Self Search Policy for a young person returning to the centre following an unauthorised absence. This will incorporate potential risk to self, risk to staff, risk to other residents. The aforementioned policy will be explained to the young person and social worker at the admission meeting and they will be encouraged to co-operate with the agreed protocols. Time Scale – Completion by: 21st June 2022	If there is supporting information of the Self Search Policy may form part of the admission meeting where young people will be informed about the protocols of the policy, and what may be expected upon their return from an unauthorised absence.
	The centre manager and the service manager must review the procedures in place in relation to young people returning to the centre following unauthorised absences.	The Service Director will undertake an immediate review of the Policy regarding return to centre from an unauthorised absence. The broad parameters of the said policy will form part of the admission process and will be explained to the young person and social worker. Completion by: 7th June 2022	The Absence / Return policy will also be discussed with the NPPT as they are the gate keepers for the service. Their agreement will be sought for policy implementation in accordance with this inspection recommendation and implementation of the same.

	The service manager must ensure the centre retains certain records for a period of time to ensure they can be included for review in significant review meetings.	The current procedure is that records are retained between ACIMS inspections and then transferred to secure storage.	The Service Director will review secure storage within the centre and arrange for certain records to be kept for SEN Review meetings. Time Scale – Completion by: 7th June 2022
	The service manager must ensure that SERG meetings are undertaken in line with centre policy and that where serious incidents occur in the centre there is a full and complete investigation of the event evidenced on the centre records.	An oversight schedule will be drawn up to cover the period May to December. This will comprise date and venue for. • SERG Meetings • Governance Visits • Supervision Schedule • Audit Reports This schedule will ensure planned compliance but in the event of a serious incident the Service Director will convene an emergency review meeting or commission an external consultant to undertake an investigation if merited.	We have a number of independent consultants who we can commission to undertake independent investigations.

	The centre manager must review the significant event register to ensure it is fit for purpose in terms of tracking patterns and trends in relation to significant events.	The Centre Manager will review the SEN register in conjunction with the service manager and quality auditor. When devised the new template will assist in tracking patterns of behaviours. The centre manager will also devise a table format document to be placed in the main care folder which will outline the staff involved, timelines and also the nature of the SEN. As this will be a one-page document in will aid in reviewing SEN's. Time Scale – Completion by: 28th June 2022	When the SEN register has been reviewed and the new system implemented, this will aid in the tracking of patterns of behaviours so that the staff team can be proactive and put in place measures to help in the reduction of SENS. The new system will be used as part of SERG meetings and team meetings to evaluate trends or patterns of incidents.
	The service manager must sign off on the audit action plan to evidence their oversight of the audit process.	The Quality Audit Reports will be signed off by the Service Director who will also sign off on the concomitant Action Plan as completed by the Centre Manager. This will also be a supervision agenda item. Time Scale: Three working days after report issued.	The Quality Audit Reports will concentrate on standards and themes. As previously alluded to these will be complemented by Corporate Compliance Reports which will have oversight by the CEO as well as Service Director level.

	The centre manager must ensure that the restrictive practice register records that there was consultation with the social worker to implement the practice and the team meeting records must provide more detail in relation to the outcome of the review of restrictive practices.	The Centre Manager will evidence consultation with the social worker and may also glean information from the social worker their perspective on recommended restrictive practices that are not contained within the Risk Assessment received at the point of referral. (ERS does not receive case histories or copious information on the young person). Time Scale – Completion by: 7th June 2022	Restrictive practices will be a standing agenda item at team meetings with analysis of effectiveness recorded. This could be informative for potential onward placements.
5	The centre manager must ensure that where they delegate some or all of their duties to one or more appropriately qualified staff members a written record is maintained of when, and to who such duties have been delegated and key decisions made.	The Service Director and Centre Manager will review the staffing 'management' levels which comprise. • Deputy Manager • Shift Team Manager • (2) Social Care Leaders Tasks will be delegated individually and collectively which will be recorded for evidence and accountability. Time Scale – Completion by: 15th June 2022. Meetings of the aforementioned staff on a weekly basis will plan and coordinate	Task delegation will be actioned and the implementation of same will be evaluated in supervision sessions under a standing agenda item and also evidenced in the centre proforma records including. • Admission Meeting • Delegated supervision. • Agency staff briefing. • Cleaning Schedules. • Team Meetings The aforementioned is not exhaustive but

		strategies for resident young people.	delegation will be collective and specific. The Centre Manager and Service Director will also define a system to handover responsibility in their absence, and an effective handover procedure for when they return.
	The service manager must ensure that they carry out their role as set out in the centres policy and procedures document to ensure there is robust external governance and management of the centre and its operations.	As previously alluded to a written schedule which incorporates governance will be set out regarding the following. • SERG Meetings • Governance Visits • Supervision Schedule • Audit Reports Further, there will be a review of the centres Policy & Procedures to ensure these are current, reasonable, in accordance with good governance and in keeping with the best practice associated with an Emergency Response Service. Time Scale – Completion by: 28th June 2022	The Service Director has drawn up a schedule for effective governance, monitoring and a systems approach which allows for ease of verification rather than adding administrative layers to an already comprehensive recording system.

	The centre manager must provide a forum for staff to review and revise centre policies particularly the policies that relate to current practice to ensure that staff practice is in line with the approved written policy.	The centre policies will be reviewed and confirmed in accordance with best practice associated with an emergency response service. The Centre Manager will ensure that all new policies and policy updates will be discussed at team meetings in order to ensure that staff have read and understood said policies	All new policies, or policy updates will be reviewed at team meetings to ensure everyone is made aware of changes. All staff will also sign said policies to evidence they have read and understood. Centre policies will be subject to review by the Service Director, and then discussed with staff at team meetings. All staff will read and sign the policies to confirm that they have understood what has just been discussed.
	The service manager must ensure all risks are appropriately identified and that the risk management framework is applied consistently across all areas of risk management.	The Service Director will liaise with the Training Officer for the facilitation of a staff workshop on risk identification and management. This will take place within the next month. Time Scale – Completion by: 28th June 2022	The Service Director and the audit process will ensure that the Risk Management Framework is completed fully and be a capable working document for staff reference.
6	The centre manager and the service manager must provide clarity in relation to the arrangements in place to ensure the young people are safeguarded throughout the night when	The Centre Manager upon review of the staffing roster is satisfied that live night staff have been deployed nightly without exception. On nights where there have been no dedicated waking night staff, the centre staff have shared the role	Live night cover is a non-equivocal staffing essential and to that effect the staffing rota will be sent to the Service Director monthly in advance.

	there is no dedicated night staff on duty. The expectations of management in relation to the supervision of the young people by staff on sleep-over duty must be relayed to staff and be risk assessed.	of waking night. The centre manager will ensure that staff team is aware of the procedures to follow in the event of no waking night. This will be discussed during a team meeting. The centre manager will also ensure that young people are aware of the night staff on duty and to that affect detail of the live night staff will be advised to young people and detail will also be placed on the notice board. A discussion will be held with young people during the admission meeting explaining night-time access to staff and safeguarding processes. An information leaflet will be provided to young people upon admission explaining night-time access to staff and safeguarding processes.	All potential staffing deficits will be highlighted by the Centre Manager as an escalation issue for resolution. The Service Director and CEO will take proportionate action which might involve authorising overtime; temporary staff transfer, deployment of agency staff; purchase of agency sourced staff.HR will be advised of staffing deficits for immediate recruitment action.
	The service manager must ensure that there is absolute clarity in relation to the appropriate numbers of staff required on the core team with regard to the number and the needs of the young people, the centres statement of purpose and the contracting arrangements with the funding body.	The Service Director is fully cognisant of the staffing numbers required. They are also equally cognisant of the ongoing challenge of staff retention in an environment where young people are stagnant on the service due to no forward placements. The needs of the young people are paramount and current staff are adjusting from what should be a 'normal' activity-based	The ERS programme is a procured service with the Statement of Purpose and Function, staffing levels and referral processes agreed with the NPPT. Staff retention has been a recent challenge but this has now stabilised which is in no small measure to the Centre Manager who has prioritised staff relationships; staff being

		diversion programme accentuating process learning, to what in the current presenting position requires a refocus on intervention strategies including education, health and work experience placements. Recruitment for additional staff in ongoing and there have been open days held, which were successful in identifying new staff.	valued; and staff work satisfaction as a retention strategy. We are currently undertaking robust recruitment to employ our own staff and significantly reduce reliance on agency staff. Our emphasis is on ensuring that all new full-time appointments will concentrate upon recruiting Social Care Qualified so as to create a minimum 50% balance in accordance with 'children residential centres staffing levels and staff qualifications requirements.'
	The service manager must also ensure the centres statement of purpose sets out the management and staff employed in the residential centre.	The statement of Purpose & Function coupled with the HBS Procurement Contract sets the benchmark for staffing numbers which we aspire to and are robustly recruiting to meet the requirement. A note of staffing level will be added to the statement of Purpose & Function. Time Scale – Completion by: 7th June 2022	The Statement of Purpose & Function will be amended to show staffing levels required through the procurement contract.

	The service manager must ensure that staff recruitment is compliant with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).	We recognise a reliance on agency staff which is diminishing due to robust recruitment, and this will accelerate to achieve our required staffing. The Service Director is unequivocal on the need to adhere to the Memo (February) and is reinforced by the CEO and our HR Department. All new staff, as well as agency staff will have their qualifications checked by both the HR Department and the Centre Manager.	The CEO issued a clear mandatory directive to all Managers in May 2022 that the Revised Memo Minimum requirements to comply with staffing levels and staff qualification requirements in children residential centres would be adhered to without equivocation. The HR Department will check every new staff member's qualification, including agency staff, prior to beginning work in the centre. The Centre Manager will also verify these as an additional control measure.
	The centre manager must ensure that a written reference from the most recent employer is secured on file as a matter of priority to ensure robust vetting procedures are in place and reference checks on staff are in line with vetting requirements.	As part of a robust governance exercise all Personnel Files have been recalled to Headquarters where the HR Department and Senior Administration Manager will scrutinise for deficits and urgently address any deficits. Time Scale – Completion by: 21st June 2022	Ensuring Personnel File completion and compliance will form part of the monthly Corporate Compliance Report (CCR). Information contained therein will be verified by the Service Director through governance visits and through quarterly audits.

	The centre manager and the service manager must set out a plan to ensure all staff receive a performance review by the end of the year.	Performance reviews will be scheduled by the Centre Manager for the month of November 2022.	The CCR will contain a section to confirm performance reviews have been undertaken and duly recorded. The Training Officer will organise an appropriate task related course for the Centre Manager.
	The service manager must ensure there are suitable on-call arrangements in place to ensure the manager has sufficient breaks from the on-call support service and that in an emergency a senior staff member can be present on-site in a timely manner.	The Service Director will refer to and review the On Call policy as contained within the Policy & Procedures document. The Deputy Centre Manager may be amenable to an on-call role as may the Shift Team Manager and Social Care Leaders in terms of responding to attending the centre. At present, the Centre Manager stays locally four nights per week so is on hand to attend the centre. It has always been, and will continue to be, a position where in the event of an emergency or serious SEN the Service Director or the CEO can be contacted for escalation purposes. Time Scale – Completion by: 28th June 2022	The On Call policy will be reviewed with a view to returning to an operational process where this is shared between senior centre staff. All staff will be made aware of the on-call policy.