An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Registration and Inspection Service

Children's Residential Centre

Centre ID number: 002

Year: 2018

Lead inspector: Linda Mc Guinness

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Registration and Inspection Report

Inspection Year:	**2018**
Name of Organisation:	**Solis MMC**
Registered Capacity:	**3 young people**
Dates of Inspection:	**8th and 9th of August 2018**
Registration Status:	**Registered from 5th of December 2017 to the 5th December 2020.**
Inspection Team:	**Linda Mc Guinness and Catherine Hanly**
Date Report Issued:	**26/10/18**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)). The Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration.

The centre was granted their first registration in 2014. At the time of this inspection the centre were in their second registration and were in year two of the cycle. The centre was registered without conditions from 5th of December 2017 to the 5th December 2020.

The centre is a large detached house which was previously owned by the HSE as part of a nearby hospital. This centre is one of a number of mainstream and disability centres run by the organisation who provide residential childcare services in the Republic of Ireland. The purpose and function for this centre had changed recently and it now provided emergency care to young people in crisis under three separate different categories. These are further detailed under standard 1 of this report.

Their model of care was described as providing high quality standard of care that is responsive to the individual needs of young people, within a child centered, supportive and safe open environment. This centre relied heavily on an activity based programme for each individual young person for the duration of their placement. At the time of this inspection there were two young people living in the centre both of whom were significantly over the timeframe stated in the purpose and function with one young person approaching 3 months in placement at the time of this report. Both young people were interviewed by inspectors and indicated that they felt well cared for in the centre and liked the management and the staff team.

Under the National Standards for Children's Residential Centres (2001) inspectors set out to examine standard 1 'purpose and function', standard 6 'care of young people (restraint aspect only), standard 7 safeguarding and child protection and standard 10 premises and safety. Whilst on site, inspectors found that there were some deficits in respect of social work role and therefore decided to expand the initial focus of the inspection to include some aspects of standard 5 'planning for children and young people' of the National Standards. Inspectors also determined that, based on the findings upon review of the standards stated above that it was appropriate to comment upon the management section of Standard 2 of the National Standards due to issues relating to governance. The inspection was unannounced and took place on the 8th the 9th of August 2018 with some follow up interviews taking place thereafter.

1.2 Methodology

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the ongoing operation of the centre in line with its registration. This inspection was announced and took place on the 8th and 9th of August 2018. The report is based on a range of inspection techniques including:

- An examination of the following documents at the centre:
  - Sample of young people's care records
  - Staff supervision records
  - Training records
  - Centre registers – admissions and discharges, complaints, grievances, and physical interventions
  - Management meeting minutes
  - Internal quality audits and action plans
  - Shift co-ordinator minutes
  - Centre policies and procedures
  - Child protection concerns
  - Risk assessments

- Interviews with relevant persons that were deemed by the inspection team as to have a bona fide interest in the operation of the centre including but not exclusively

  a) The centre manager
  b) The Emergency Response Service National Co-ordinator
  c) The Service Manager
  d) One shift coordinator
  e) The two young people residing in the centre at the time of the unannounced inspection

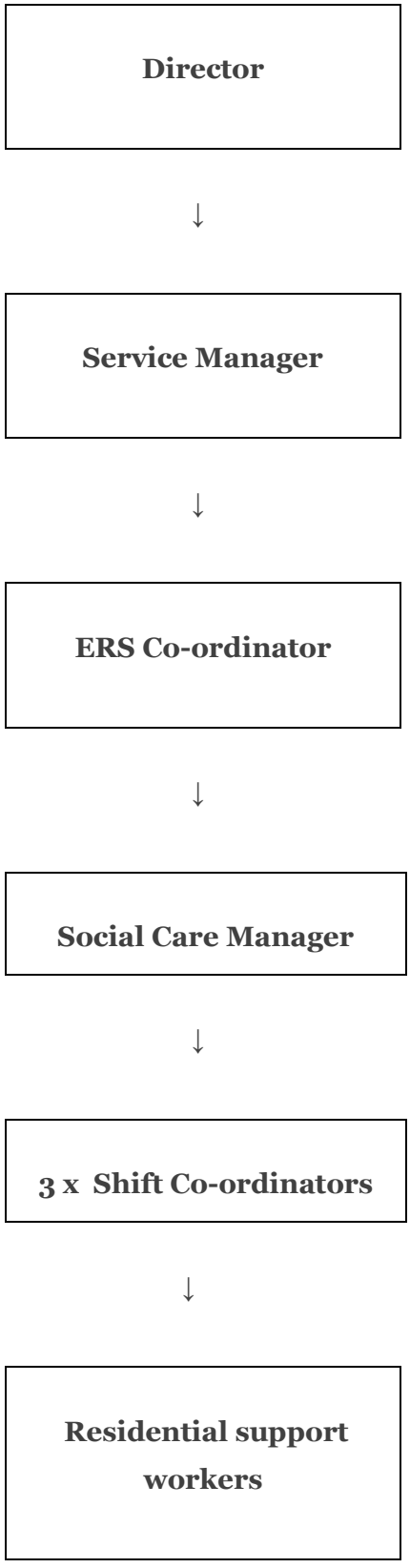
- Communication with the lead inspector with responsibility for oversight of this centre.

- Communication with the principal social worker for a young people who was previously resident in the centre

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.

1.3 Organisational Structure



2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 20th September 2018. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 4th of October and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the 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 conditions from 5th of December 2017 to the 5th December 2020 pursuant to Part VIII, 1991 Child Care Act.

3. Analysis of Findings

3.1 Purpose and Function

Standard
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

3.1.1 Practices that met the required standard in full
None identified

3.1.2 Practices that met the required standard in some respect only
The centre had a written statement which described the intended purpose and function. The centre had recently changed its purpose and function following consultation with the Tusla national private placement team. The previous purpose and function was to provide short term respite care for up to three young people (boys and girls) between the ages of 12 and 17 years of age. At that time each placement was intended to be provided for a maximum of seven days with the possibility of an extension to 14 days if necessary.

The revised purpose and function provided to inspectors stated that the centre would cater for three young people within three different categories. These were:
Category 1 – Young people whose placements had broken down and who required a bridging placement for a maximum of 7 days (with a possible extension to 14days). Two of the three placements in the centre will fall within this category.
Category 2 – This category was intended to respond to young people in an emergency situation but who can return home or to their previous placement. This must take place within a 21 day period. If this is not possible then the young person is re – categorised as a category 1 placement. One placement can fall into this category.
Category 3 – Depending on occupancy levels the centre may provide a 24 hour emergency 'out of hours' placement to a young person in crisis and referred through the Out of Hours service.

This purpose and function had been in place since January 2018. Inspectors found that of 16 admissions to the centre from January 2018 to August 2018 only 4 were 14 days or less in duration. The average stay for the other young people at the time of inspection was 28.6 days each. All of these placements fell into category 1 as outlined above. Inspectors note that there have been some improvements in the length of stay

for some of the young people since the time of last inspection however the average was significantly outside that stated in the purpose and function. This was mainly due to a lack of move on placements on a national basis within the child and family agency.

The manager and ERS co-ordinator informed inspectors that the systems were not yet in place to fully accommodate young people under category two as this required intensive support mechanisms to facilitate young people returning home or to their other identified placement. The statement was due for annual review and there were systems in place whereby the senior management team held regular meetings with the National Private Placement Team NPPT to review the service.

There was a version of the purpose and function available to young people however this was not updated since the agreed changes. The centre relied on social workers to communicate with parents about the nature of the service and a booklet was not available for parents outlining the nature of the service.

Inspectors found that the staff members were familiar with the content of the statement however it was noted by staff who were interviewed by inspectors that the excessive length of placements did impact negatively on the service on offer. The centre primarily offers an activity based programme and this was not possible to deliver on an individual basis for extended periods. It was evident that young people became frustrated with the lack of a move on and were often not willing to continue to engage in daily activities. One young person interviewed expressed their frustration at a lack of a move on to another placement.

3.1.3 Practices that did not meet the required standard

None identified

Required Action

- Centre management in consultation with the National Private Placement Team must ensure that the length of stay for young people in the centre is in line with the stated purpose and function
- Centre management must en sure that the centre information booklets are revised.

3.2 Management and Staffing

Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

3.2.1 Practices that met the required standard in full

None identified as not all criteria was assessed during this inspection

3.2.2 Practices that met the required standard in some respect only

Management

This centre was being managed at the time of this inspection by an appropriately qualified person who had been in the role since late October 2017. This was initially an acting post to into which they were subsequently permanently appointed. This person had previously been in shift co-ordinator role for 18 months within the centre and had acted for the centre manager when they had periods of leave. There were systems of management and oversight in place which included regular oversight of records and registers, attendance at team meetings and staff hand over, supervision of the staff team, submitting manager reports and attendance at management meetings. Inspectors found from review of the centre records and from interview with the staff team that the manager was providing robust leadership and good support to the team. The staff members and senior management interviewed by inspectors were confident in the manager's abilities and felt that they provided excellent management across all aspects of service provision. They were present in the centre at least four days per week. There was evidence that the manager noted issues of concern or importance and promptly escalated these through the appropriate channels. There was a system in place whereby the ERS co-ordinator would stand in for periods of leave by the centre manager.

There was an external management structure in place which included regional managers, quality assurance team and links to the clinical team.

The centre manager was supervised by the national co-ordinator for the ERS services who in turn reported to the National service manager. It was reported that the line manager for this service should be present in the centre at least every two weeks and attend team meetings. While the centre manager reported a good working relationship and significant informal support inspectors could not find sufficient

evidence of these formal visits and the line manager's oversight of the operations in the centre.

The centre manager completed a monthly report for senior management and the quality assurance manager who had their own auditing systems in place. During this inspection, inspectors reviewed one such audit which had taken place in March 2018. There was evidence of feedback from the quality assurance manager to the centre manager with clear details of actions required including supervision and training. The manager had completed an action plan in response to issues identified within 5 working days. Inspectors note that one of these actions relating to core mandatory training was still outstanding at the time of this inspection.

During the 2017 inspection the management reported an increased emphasis on governance within the organisation as evidenced in particular by the quality assurance role. There was a recommendation that centre management must demonstrate an improvement in their auditing and governance systems. During this inspection inspectors found evidence of some improvements; however deficits remained in respect of some aspects of governance. These included an incomplete vetting process for one staff member to include a risk assessment. This had been highlighted as an area which required improvement in a previous inspection. Another area which required significant improvement had also been flagged as a deficit in a previous report. This was the lack of evidence of a feedback loop to the centre manager from their line management. During this inspection the social care manager had written formally to line management raising concerns about a specific issue. While they reported that there was verbal follow up, inspectors found no evidence that these issues had been formally responded to in line with good governance and best practice.

The issue of clarity in respect of distinguishing the difference between complaints and allegations was an action required from the 2107 inspection. Inspectors note that this is still an issue of concern which required urgent attention.

Inspectors found that there was some incongruence between HR policies and safeguarding policies within the organisation. While there were examples of gross and general misconduct within the grievance and disciplinary policy, there was no specific established code of conduct for staff outlining clear expectations of behaviour during their employment. There was a whistleblowing policy in place however it appeared that there was a lack of understanding as to whether action would be taken if a verbal report was made to line management. Inspectors noted that there was

reluctance on behalf of staff to use the policy to report concerns which they had raised through other forums. This should have been picked up by management and addressed as a matter of priority.

Inspectors found that there was a gap in the records of senior management meetings whereby there was no record of a meeting taking place between January and July 2018. At the time of this inspection they had recommenced and were taking place every fortnight.

3.2.3 Practices that did not meet the required standard

None identified

3.2.4 Regulation Based Requirements

The Child and Family Agency met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV, Article 21, Register.***

The centre met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996 -Part III, Article 5, Care Practices and Operational Policies***
Child Care (Placement of Children in Residential Care) Regulations 1995 -Part III, Article 6, Paragraph 2, Change of Person in Charge
Child Care (Placement of Children in Residential Care) Regulations 1995 -Part III, Article 16, Notification of Significant Events.

Required Action

- Senior management must ensure there is robust line management for the centre and that there is evidence of this across records and contacts.
- Senior management must ensure that there is a policy in place respect of a code of conduct. The policy in respect of protected disclosures must be reviewed to ensure it is fit for purpose and fully understood by the staff team.
- Senior management must ensure that required actions required from inspection findings and reports are fully implemented

3.6 Care of Young People

Standard

Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

3.6.1 Practices that met the required standard in full

None identified

3.6.2 Practices that met the required standard in some respect only

Restraint

Restraint was not a feature in the centre at the time of this inspection. Inspectors noted that one of the staff team was not trained in recognised the model of behaviour management which includes restraint. This was despite being appointed in January 2018 and this being picked up in an internal audit by the quality assurance team. There were systems in place to ensure that all staff received refresher training in line with the policy. This saw staff receive training every six months or three hours of training every three months.

There was a register of physical intervention in place which was opened on 01/01/18 and there were no entries on this register. The 2017 register showed that two physical interventions had taken place since the last inspection on 2017. There was evidence that these were reviewed for learning purposes as recommended in the last inspection report. The 2017 inspection report also recommended that the manager must ensure robust oversight of the recording in the centre as it pertained to the practice of physical intervention and in doing so satisfy themselves of the accuracy and detail within these records. Inspectors noted that on occasion the staff team had been required to conduct a non-routine intervention with a young person to ensure safety. This was an intervention which is not in line with the approved model of behaviour management and may involve minimal physical contact. These incidences are not record as a physical intervention and may be only noted in the body of the report or in the detail of a significant event. This would make it very difficult to track these interventions for patterns or themes in line with best practice. Inspectors recommend that all such interventions are clearly recorded in the report, on the register and are subject to review as with any restraint.

It was also noted that there were good practices in place in supervision in respect of reviewing the number/nature of significant events that a residential social care worker was involved in since their previous session. However, this was not in place for shift co-ordinators and could lead to some patterns being missed. Inspectors recommend that this is in place across supervision of the entire team.

3.6.3 Practices that did not meet the required standard

None identified

Required Action

- Centre management must ensure that all staff working in the centre have received the mandatory training in respect of the model of behaviour management in place
- All physical interventions (including non-routine) must be clearly recorded for tracking and review purposes

3.7 Safeguarding and Child Protection

Standard

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

3.7.1 Practices that met the required standard in full

None identified

3.7.2 Practices that met the required standard in some respect only

The centre has a written child safeguarding statement which is displayed and references the risk assessment and relevant policies. There were policies in place to ensure safeguarding of young people with which the management and staff team were familiar. These included: recruitment and vetting of staff, induction, training, supervision, complaints, children's rights, lone working and family access. There was reference in the child protection policy about appropriate professional boundaries, appropriate clothing, physical touch, risk assessment and providing a safe environment. Young people could make and receive calls in private where appropriate and they were made aware of organisations and individuals who could advocate on their behalf.

As referenced previously there was a whistleblowing policy in place whereby staff members were encouraged to express concerns about attitudes and practice of

colleagues. This policy had been in place since 2012 and should be reviewed. As mentioned previously there was no established code of conduct in place. Inspectors interviewed four staff members and one person who had recently left the service. It was evident that there was a lack of clarity about the whistleblowing policy and its implementation. Staff members were not clear if action would be taken by management if a verbal report was made under the policy. Also management did not seem to be clear; as it appeared that they understood that a written report was required in order for disciplinary action to commence. This was also the advice of the human resources department. The policy itself indicated that action could be taken on receipt of a verbal report. This confusion and conflicting information may have contributed to staff members not being comfortable using the whistleblowing policy or managers taking appropriate action when it may have been deemed appropriate. Furthermore, when disciplinary action was required the action taken did not seem to follow the organisations own policies.

Child Protection

Standard

There are systems in place to protect young people from abuse. Staff are aware of and implement practices which are designed to protect young people in care.

3.7.3 Practices that did not meet the required standard

Inspectors note that the child protection policy which was submitted following inspection had not been updated and refers frequently to Children First, National Guidance for the Protection and Welfare of Children 2011.

It referenced old reporting procedures where reporting went through a designated liaison person and there was no reference to mandatory reporting in line with new legislation. It had no reference to the updated version of Children First – National Guidance for the Protection and welfare of Children 2017. This was evidenced in interview with one staff member who was uncertain and unable to describe to inspectors the revised reporting procedures. Also, the policy had not yet been updated to include reporting through the Tusla on line portal.

Staff members had all received training in the Tusla e learning child protection programme but management must ensure that this is supplementary to comprehensive child protection training.

National Standards dictate that supervising social workers are aware of all significant events (including complaints and allegations) and take appropriate action on receipt of written notifications. Inspectors found on review of centre registers and care files

that one young person raised an issue where they alleged physical assault by a staff member. This was incorrectly sent to the social work department as a complaint and not an allegation. The social work department did not reclassify this as an allegation. It was not processed from the centre under the correct child protection reporting mechanisms. There was no internal review of the incident and the centre manager requested that the social work department respond as a matter of urgency as the young person was due to move on from the centre. The social worker was on leave and a member of the senior team responded promptly and came to the centre to meet with the young person. Whilst there was prompt reporting to the social work department of the issue and a quick response, inspectors note that there were deficits in how this was managed. A previous inspection report highlighted that the centre had incorrectly managed allegations as a complaint and action had not been taken to ensure that this did not happen again. The 2017 inspection report recommended that centre management must ensure that there is absolute clarity regarding the understanding and management of complaints and allegations. This issue must be addressed as a matter of urgency.

Inspectors found that there were deficits in the manner in which this issue was handled by both the centre and the social work department. There was no evidence of either an internal or external investigation process and no one other than the young person was interviewed when the matter was being reviewed by the social work department. The conclusion was that the 'complaint' was determined by the social work department as unfounded. Inspectors could not find evidence that this information was given to the young person and that they were made aware of their right to appeal. The principal social worker responded to the inspection team who made enquiries about this matter. They confirmed that it was processed only as a complaint and said that the young person was fully aware of their rights.

Required Action

- Centre management must ensure that all policies and procedures are relevant to the regulations and updated Children First National Guidance for the protection and Welfare of Children
- Centre management must ensure that there is absolute clarity regarding the understanding and management of complaints and allegations.
- The supervising social work department must ensure that allegations of abuse are investigated thoroughly and that young people are informed of the outcome.

- Centre management must ensure that the organisational policy is followed where an allegation relates to staff practice.
- Centre management must ensure that there are policies in respect of a code of conduct and protected disclosures which are understood by all and evident in practice.

3.10 Premises and Safety

Standard

The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

3.10.1 Practices that met the required standard in full

Accommodation

The centre was located in a building previously used by the Health Service Executive for health care. While the staff team made every effort to decorate it domestically it is difficult to achieve. Young people had a room to themselves. The team made every effort to include them in decorating their room with posters and soft furnishings. Inspectors noted that other areas in the centre were quite bare and would benefit from some attention to improve aesthetics. A walk through the centre identified some minor issues that the centre manager agreed to address. Most of the recreation for young people takes place off site in line with the activity based programme and the intended short term nature of the placements.

Maintenance and repairs

Previously any repairs relating to structural or maintenance issues had to go through the Health Service Executive as the building was leased from them. The organisation has recently taken over the responsibility for the maintenance and repairs to the centre. They have contracted this out to a service provider. This has resulted in much quicker response times for issues requiring action. During a walk-through of the centre with the social care manager a number of issues requiring attention were highlighted. The centre manager must update the registration and inspection service when these issues are addressed. Premises, maintenance and safety form part of the auditing process by the quality assurance team. Discussions relating to these issues were also evident at senior management level.

Safety

The centre had an up to date health and safety statement which was signed 02/01/18. There were systems in place for reporting accidents or incidents. Staff members were trained in first aid. There were mechanisms in place to ensure the safety and upkeep of centre vehicles. Medicines were stored safely and administration of medication recorded appropriately. Health and Safety audits were completed on a monthly basis and any hazards were reported promptly and followed up. There were site specific risk assessments in place for each young person.

3.10.2 Practices that met the required standard in some respect only

Fire Safety

There is written compliance in respect of fire safety regulations. An external company was now responsible for fire safety equipment. They had visited the centre to check appliances in September 2017 with a follow up visit in July 2018. Fire safety procedures were in place and staff had received training in fire prevention and evacuation. Recent fire drills had taken place on 08/03/18, 12/04/18, 03/05/18 and 06/06/18. These were all completed in line with the admissions policy for the centre. These drills contained initials of young people. No staff names were listed. No issues with evacuation were noted. These records showed evidence of oversight by the centre manager.

One staff member was designated responsible for reviewing and monitoring fire safety within the centre. There were daily inspections of the means of escape. The location of fire extinguishers must be recorded in the fire register. Inspectors noted that two fire extinguishers were stored on an upstairs landing. The social care manager explained on occasion that they have been removed as a measure to manage the environment if safety was an issue. This measure was only recorded in the body of a significant event and there was no risk assessment to accompany this decision. Centre management must ensure that this decision is properly risk assessed and recorded appropriately if required.

3.10.3 Practices that did not meet the required standard

Actions Required

- Centre management must ensure that there is evidence of risk assessment and review when fire extinguishers are moved from their dedicated spaces.
- Centre management must ensure that records of fire drills contain information relating to all persons present and notes any issues relating to evacuation of the premises.

3.10.4 Regulation Based Requirements

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996,***

-Part III, Article 8, Accommodation

-Part III, Article 9, Access Arrangements (Privacy)

-Part III, Article 15, Insurance

-Part III, Article 14, Safety Precautions (Compliance with Health and Safety)

-Part III, Article 13, Fire Precautions.

4 Action Plan

Standard	Issues Requiring Action	Response	Corrective Or Preventative Strategies To Ensure Issues Do Not Arise Again
3.1	Centre management in consultation with the National Private Placement Team must ensure that the provision of care in the centre is in line with the stated purpose and function	As the report alludes to, the length of stay is comprised by the failure to source a suitable onward placement for young people. We have raised this matter with the NPPT and we will do so again at our next review in October. We will amend of referral form to advise referring Social Workers of the time limited nature of the placement and we will verbally advise them on the same	At our review meeting with the NPPT on the **25th October 2018** we will advise the following. • That we cannot extend placements beyond the time periods as specified in our Statement of Purpose & Function. • We will recommend amendment of our referral form to advise referring Social Workers of the time limited nature of the placement and we will verbally advise them on the same. • We will recommend that the NPPT and the referring social worker give 'reasonable' assurance that an onward placement can be sourced. Failure to receive such an assurance may result in the placement not being offered.

	Centre management must ensure that the centre information booklets are revised.	To this point the Solis MMC Booklets have been generic and have served all centres across the organisation. However these will now be amended to reflect the specifics of the ERS programme.	By **03rd December** the amended versions of the Centre Information Leaflets will be completed.
3.2	Senior management must ensure there is robust line management for the centre and that there is evidence of this across records and contacts.	The ERS National Coordinator and the Service Manager attend the centre on a fortnightly and Monthly basis respectively.	Effective **immediately** the ERS National Coordinator and the Service Manager will sign off on centre records while visiting the centre and thereby exercise governance oversight and responsibility.
	Senior management must ensure that policies and procedures in respect of a code of conduct and protected disclosures are reviewed to ensure they are fit for purpose and are fully understood by the staff team.	Solis MMC is in the process of amending the employee handbook, which is heavily influenced by the HSE and Tusla handbooks, which will have robust sections including. • Dignity at Work • Whistle Blowing • Disciplinary Procedures The handbook will be distributed to all staff and training will be provided on same.	By **03rd December** the Employee Handbook will be printed and distributed to all staff. Training on the same will be completed by 03rd December through the medium of Team Meetings and Supervision sessions.

	Senior management must ensure that recommendations from inspection processes are fully implemented	The Service Manager will have oversight and ensure that all recommendations are implemented.	Effective **immediately** the Service Manager will ensure that all recommendations are implemented in the ERS programme. He will also ensure that recommendations as appropriate for centres across the company are discussed at the October operational Management meeting for implementation.
3.6	Centre management must ensure that all staff working in the centre have received the mandatory training in respect of the model of behaviour management in place All physical interventions (including non-routine) must be clearly recorded for tracking and review purposes	As stated all employees will receive the employee handbook and training in behaviour management in the workplace. Effective immediately we will clearly record all physical interventions.	By the **03rd December** we will introduce the employee handbook and provide training on the same. Effective **immediately** we will clearly record all physical interventions. This will be monitored by our internal Quality Auditor who will advise the Director where there are any deficiencies in recording.
3.7	Centre management must ensure that all policies and procedures are relevant to the regulations and updated Children First National Guidance for the protection and	We were of the opinion that the Tusla e learning child protection programme was sufficient to meet that mandatory training component. However, upon advice from this	By **03rd December** all staff will be trained in the Children's First with emphasis on the updated version of Children's First – National Guidance for the Protection and

	Welfare of Children	inspection report we will reintroduce the Children First Training	welfare of Children 2017.
	Centre management must ensure that there is absolute clarity regarding the understanding and management of complaints and allegations.	Solis MMC Children's Services will ensure clarity of reporting in terms of complaints and allegations.	From **January 2019**, as part of the internal Quality Audit process, the Auditor will randomly interview staff to ensure understanding of this guidance.
	Centre management must ensure that the organisational policy is followed where an allegation relates to staff practice.	Organisational policy relating to allegations against staff will be strengthened to ensure that allegations, as made, are fully investigated and concluded. Particular attention will have to be paid to the employment and rights of employees. This will be reflected in the Employee Handbook to give clarity in the event of an allegation.	Effective i**mmediately** all complaints related to physical assault or untoward actions, levied by a young person against a staff member will be treated as an allegation. By **03rd December** a policy document giving Managers' clarity on an allegation or complaint will be circulated. Also by the **03rd December** the employee handbook will be circulated to all employees and the policy regarding allegations against staff members will be discussed.
	Centre management must ensure that there are policies in respect of a code of conduct and protected disclosure which are understood by all and evident in practice.	The Employee Handbook will describe the code of conduct expected from staff within Section 3 – Employment Policies	By the **03rd December** the Employee Handbook will be circulated and the code of conduct, et al, discussed at team meetings and supervision sessions as an agenda item.

	The supervising social work department must ensure that allegations of abuse are investigated thoroughly and that young people are informed of the outcome.	Screening interview with staff and young person did not warrant an I.A.	Going forward all allegations to be responded to in writing and the reasons for reaching that outcome as per the Tusla complaints policy.
3.10	Centre management must ensure that there is evidence of risk assessment and review when fire extinguishers are moved from their dedicated spaces.	Where there is a need to remove Fire Extinguishers to immediate accessible locations this will be recorded as part of a risk assessment strategy.	Effective **immediately** the removal of Fire Extinguishers to assessable locations will be recorded as part of a risk assessment strategy. This will be monitored by the ERS National Coordinator and the Service Manager for governance and compliance.
	Centre management must ensure that records of fire drills contain information relating to all persons present and notes any issues relating to evacuation of the premises.	The records of fire drills will be comprehensively recorded.	Effective **immediately** Solis MMC will apply the fire safety guidelines and requirements as contained with the HSE Fire Safety Register,