An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 003**

**Year: 2022**

# Inspection Report

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|---|---|
| **Year:** | **2022** |
| **Name of Organisation:** | **Fresh Start Ltd** |
| **Registered Capacity:** | **Four young people** |
| **Type of Inspection:** | **Announced** |
| **Date of inspection:** | **29th,30th & 31st of March 2022** |
| **Registration Status:** | **Without attached conditions from 8th April 2020 to 8th April 2023** |
| **Inspection Team:** | **Catherine Hanly**<br>**Lorraine Egan** |
| **Date Report Issued:** | **7th July 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 08th April 2011. At the time of this inspection the centre was in its fourth registration and was in year two of the cycle. The centre was registered without attached conditions from the 08th April 2020 to 08th April 2023.

The centre was registered as a multi-occupancy centre to provide care for up to four children of both genders from age thirteen to seventeen years on admission. The centre operated a needs assessment model of care with the aim being to offer children a safe caring environment delivered through a nurturing system. The model is described as having clearly defined boundaries and expectations that responds to the child's immediate needs. There were four young people living in the centre at the time of the inspection, three of whom had been resident at the time of this centres last inspection in May 2021. The fourth child, who was outside of the centre's stated age range, was placed in the centre following an approved derogation progress with the Tusla Alterative Care Inspection and Monitoring Service.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| 2: Effective Care and Support | 2.3 |
| 5: Leadership, Governance and Management | 5.2 |
| 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 and to the relevant social work departments on the 11th of April 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 3rd of May 2022. The initial CAPA was not deemed to be satisfactory and so the inspector scheduled a meeting with the centre manager to discuss the content of the CAPA, identify where additional and more robust responses were required, and to further discuss factual inaccuracies identified. A second CAPA was submitted on the 31st of May as agreed. The finalisation of the policy and procedure document remained outstanding at the time of this report being issued.

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: 003 without attached conditions from the 8th April 2020 to 8th April 2023 pursuant to Part VIII, 1991 Child Care Act.

## 3. Inspection Findings

**Regulation 8: Accommodation**
**Regulation 13: Fire Precautions**
**Regulation 14: Safety Precautions**

**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.**

Inspectors observed that the layout of the residential centre allowed for delivery of safe and effective care to a maximum of four young people. Each young person had their own bedrooms, and all were ensuite. Young people were facilitated to decorate their bedrooms to their own taste, and this was confirmed during inspector's onsite visit. They could store personal items safely and securely in their own bedrooms or in the staff office. Inspectors suggested that the centre manager give some consideration to providing young people with keys for their own room in accordance with their age, developmental stage, and capacity, supporting their independence in this regard. There were large communal areas within the centre to facilitate indoor activities and recreational time for young people. In addition, these also allowed for visitors to meet with young people in privacy at the centre.

The inspector observed during their onsite visit that there were indoor and outdoor recreational resources for young people including board games, arts & crafts materials indoors, and a swing set and trampoline outside. However, inspectors asked that the centre manager verify whether the trampoline was secured to the ground surface in accordance with the manufacturer's guidance. The inspector observed that the premises was clean on the day of the onsite visit but found that it was lacking in aesthetic furnishings that would lend themselves to creating a homely environment. Centre management argued that they have invested funds in purchasing soft furnishings and for decorating purposes and provided receipts to this effect. Inspectors suggest that the centre manager and staff team continue to have an awareness of the physical environment for young people and satisfy themselves that it continues to be suitably aesthetic in creating a homely environment.

The residential centre was adequately lit, heated, and ventilated on the day of the inspector's visit and there were no significant deficits highlighted in these broad areas in the maintenance records. The garden area to the front and rear of the property

was large but generally unused by the young people. The lawn to the rear was partially cut on the day of the inspector's visit. Inspectors noted that the exterior of the property had not been painted, despite this matter having been highlighted by inspectors in May of 2021 at the time of the centre's last inspection. Senior management from the company had communicated with management in Alternative Care Inspection and Monitoring Service (ACIMS) about this matter in November 2021 committing to addressing this. However, this action had not been achieved at the time of this inspection. Although senior management committed to inspectors that this was identified to the company's maintenance team, no date of completion had been set. Inspectors were provided with evidence of the system in place for recording and reporting accidents/injuries. Two records on file of two recent accidents were reviewed by the inspector and found to be in accordance with stated policy. There were two vehicles for use by the centre. There were records of regular services of these, they were found to be taxed and insured at the time of the inspection. The staff team were licensed to drive these, records of licenses were provided to inspectors for review.

The centre's fire register included detail on daily and weekly checks, and recording of same, in relation to fire safety. Most of the staff team, including some relief had completed fire safety awareness training. Those that had not were awaiting dates to be scheduled. There was evidence that fire drills were taking place, with four having been conducted within the previous twelve months. However, full details were not being consistently recorded, for example the initials of the young people present in the centre and participating in the drill was not in all records; the time that the drill took place was not always stated so inspectors' and senior management could not determine if a night-time drill had been completed. An annual service of fire fighting equipment had last been conducted mid-December 2021.

Inspectors were provided with a Health and Safety policy statement, signed by the company CEO dated March 2022. This one-page document noted the company's commitment to ensuring that all premises are kept in a clean and safe condition, however, inspectors found significant issues of concern with the potential to impact on the health and safety of the young people in this centre. There was no specific policy on fire safety. There were lengthy delays identified relating to the response to reported fire safety matters. These included upstairs emergency lighting which was recorded as not working and remained unaddressed for three weeks; emergency lighting in the conservatory was recorded as not working and was not addressed for nine weeks; a leak in the ceiling, which was recorded as dripping through the lightbulb was reported and not completed for three months; and the self-closer on a

young person's bedroom door was identified as not working in mid-April 2021. There was no completion date listed in the maintenance book and the centre manager subsequently confirmed that the self-closer issue was completed mid-June 2021. The proprietor must ensure that a review is undertaken by a qualified engineer/fire safety officer to verify that the fire alarm and emergency lighting system is fully operational following the identification of the issues detailed here.

Inspectors found that there had been ongoing problems with the plumbing system dating back to at least 2020. These problems had resulted in toilets and shower drains backing up, overflowing, and not functioning properly; leaks within the system; and toilets and showers being out of use as a result. Inspectors found from evidence gathered that the responsiveness to maintenance matters overall, but especially those that posed a health and safety risk to young people and staff was unacceptably slow. For example, a reported sink blockage in the downstairs toilet had taken two months to be resolved successfully by maintenance. There were problems recorded with one young person's toilet in August and November 2021 and their shower in March 2022. Although some remedial work had taken place, including the replacement of the cistern with a new toilet and cistern, and frequent rodding to clear the sewerage system, these had not been entirely effective in resolving the issues fully. Inspectors noted that although there was generally good recording and reporting of deficits to maintenance, these could have been more detailed and more thorough in documenting when matters were reported for a second or third time and all actions taken by maintenance. Inspectors noted that a young person had named their dissatisfactions with the ongoing plumbing issues in 2021 and the impact of same however there was no evidence that this had been effectively responded to. Hearing young people's voices and clearly recording their views was a matter that was identified as an issue in the inspection of this centre last year.

The manager had been recording in their monthly governance audits that there were ongoing maintenance issues, however these were, on occasion, non-specific and there were no action plans outlined to address them. The deficits with the plumbing had also been included in the centre risk register, however it was risk rated as '3', a very low rating and there was no evidence of how, or indeed if, matters were escalated from the risk register. This will be discussed further under 5.2 of this report. The proprietor must address the deficits related to plumbing and provide evidence of this to inspectors.

The quality assurance and practice manager that signed these governance reports and used them to inform their audits of the centre had not picked up on the lack of action

places. In addition, two separate reports conducted in 2021 noted that the manager was to ensure that maintenance matters were responded to, and that the maintenance team assigned were "prompt". Inspectors were informed that the proprietor was responsible for managing the maintenance team therefore it was their responsibility to action matters and ensure that they were successfully completed. Instead, these were delegated to the centre manager, who is not responsible for this aspect of service provision. The evidence gathered and reviewed by inspectors does not support the latter statement, in fact the contrary is more accurate. Inspectors found that the systems in place regarding the escalation, management, and response to deficits in the property related to health and safety were inadequate and required immediate attention from the proprietor.

| **Compliance with regulations** | |
|---|---|
| **Regulation met** | **None identified** |
| **Regulation not met** | **Regulation 8**<br>**Regulation 13**<br>**Regulation 14** |

| **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** | **Not all standards under this theme were assessed** |
| **Practices did not meet the required standard** | **Standard 2.3** |

**Actions required**

- Centre management must identify a realistic completion date for the painting of the outside of the property.
- Centre management must ensure that there are appropriately detailed records of fire drills and maintenance issues, including completion dates, maintained at the centre.
- The proprietor must ensure that a review is undertaken by a qualified engineer/fire safety officer to verify that the fire alarm and emergency lighting system is fully operational following the identification of the issues detailed here.
- The proprietor must address the deficits related to plumbing and provide evidence of this to inspectors.
- The proprietor must put in place the necessary procedures for managing risks to the health and safety of children, staff, and visitors in this centre. This

should include a clear and effective risk escalation system that demonstrates knowledge of health and safety risks.

**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 had been allocated to their current post in June 2020 from within the company when the position became vacant. The staff members interviewed for this inspection identified the centre manager as a leader in a practical sense in that they were responsible for the overall delivery of care practices at the centre and by virtue of their role. They were the identified person in charge with overall executive accountability, responsibility, and authority for the delivery of the service within the centre. There was evidence across records reviewed and from interviews that they had good oversight and knowledge of all aspects of service provision in this centre. There was clarity in terms of roles and responsibilities within the centre however staff interviewed did not demonstrate a sense of being formally held accountable for their day-to-day work. Inspectors found that the manager had a significant workload and was stretched in their ability to fully deliver on all aspects of their allocated duties and responsibilities. The four allocated social workers identified the centre manager as their point of contact for this centre. Three of the four appointed social workers could not identify to the inspector who their child's appointed keyworker at the centre was.

The manager was being supported in their role by a deputy manager, and there was a recorded delegation of tasks and duties to them, as well as to key workers and shift leaders, the latter of which was a very recent introduction to this centre. The deputy manager was the appointed person to act up when the manager is absent, although this had not yet happened since the deputy manager commenced in post. However, inspectors found that the manager was not adequately supported in their role by senior management. This centre did not operate a social care leader system with dedicated additional responsibilities and opportunities for career progression and additional support to assist the manager in delivering on good governance. At the

time of this inspection, and for the preceding ten months, there had been ongoing difficulties in staffing the centre on a full-time basis to adequately support the needs of the children placed there. The previous fulltime deputy manager had vacated their post in August 2020, at a time when the staff team was challenged by the placement of a young person with significant emotionally and behaviourally complex needs. The new person appointed to the role of deputy manager, who commenced three weeks later did not have the required supervision training and therefore was unable to assist the manager in that task. The lack of supervision was a consistent deficit noted in monthly manager's audit reports and in the audits conducted by the quality assurance and practice manager. It had a noted impact on issues related to staff cohesion, workload amongst the staff team and delivery of professional practice and accountability for same. This will be detailed further under standard 6.1 of this report. The proprietor must make the necessary structural changes to ensure that the internal management structure of this centre is appropriate to its size and purpose and function.

Inspectors did not find that sufficient evidence during this inspection to support the fact that there was a culture of learning, quality, and safety in the service. This is evidenced by the findings detailed under 2.3 of this report; the lack of regular discussion at team level of operational policies and procedures; and the lack of recorded learning based on reviews of events/situations that related to young people.

The registered provider had a service level agreement in place and arrangements had been identified to meet with the Tusla as the funding body and provide reports of compliance with relevant legislation and the national standards. However, the operations manager confirmed with inspectors that whilst meetings had been convened by Tusla previously, since the agreed contract was secured in August 2021, no such meetings had occurred and neither had the funding body sought any such reports of compliance.

The operations manager provided inspectors with a copy of the updated and reviewed organisational policies and procedures document. This had been repeatedly requested of the service provider across several inspections throughout 2021 and whilst the requests had been responded to, a satisfactorily updated and completed document had not been submitted. Inspectors found that the policy document submitted for this inspection did not fully take account of the current national standards and thus requires further review and amendment. The registered provider must take immediate corrective action to address this deficit and senior management

must then put a plan in place for the prioritisation of the rollout of the policies and procedures to inform the staff team.

Inspectors found deficits at senior manager level in terms of governance, oversight and support provided to the centre manager. Staff noted in their request for feedback on retention incentives that they would like to see more of senior management representatives at the centre. Inspectors found that there was no clear structured plan for the quality assurance and practice manager to conduct audits at this centre. There was also no evidence to indicate that audits were responsive in nature, nor were they targeted at shortfalls being identified within the manager's own monthly reports, such as issues relating to delivery of formal and regular supervision, or difficulties within the staff team. These matters reflect similar findings related to oversight and governance in other centres operated by this company. The shortfalls identified in the manager's reports and the three audits that had been conducted in the last twelve months lacked comprehensive action being assigned and, in some cases, lacked any action identified at all. Despite the manager being stretched in their duties and identifying deficits, there was no immediate and supportive action implemented by senior management. The audits conducted by the quality assurance and practice manager must be more frequent, more responsive, and more supportive to the delivery of the service.

Inspectors found evidence in interviews and from records reviews of a poor demonstration of knowledge and application of theory to practice related to the understanding and implementation of a risk management framework. The evidence gathered did not support a thorough understanding of risk identification, rating in accordance with the centre's own risk matrix, escalation pathways and management. Inspectors were directed to young people's crisis and absence management plans (ICSP & IAMP). The content of ICSP's, was found to be general rather than specific in targeting the identified behaviours. These were devised by the company's crisis intervention trainer and there was no evidence of their guidance or any shared learning at team meetings. Inspectors also noted that these were documented as having been updated/reviewed, however there appeared to have been instances of 'cut and paste' with incorrect dates, no signatures to substantiate an actual review. Inspectors were informed that significant events (SEN's) were reviewed at multidisciplinary meetings (MDT) with the clinical team which happened monthly. These reviews were intended to inform the ICSP's however inspectors found that the detail recorded in the minutes of these meetings was limited and vague rather than specific in content. The centre manager must ensure that significant events and the young persons' related ICSP be discussed are team meetings on a regular basis

separate to the MDT for the purpose of learning and to ensure consistency of practice.

The centre had a risk register that was reported as being subject to monthly review by the centre and operations managers. The content of this register had not been appropriately updated and amended to take account of changes within the centre. Staffing was identified on this register as an issue with a rating of 9 following the admission of a young person that presented with serious risks. This had remained unchanged across a period of nine months despite the manager and operations manager acknowledging to inspectors that the centre was understaffed and that they had been highlighting this for some time. The only management factors identified to mitigate this risk were quarterly recruitment processes and risk assessments if deemed necessary. Detail in the register was limited and did not demonstrate a comprehensive understanding of weighting risks and implementing appropriate mitigating practices. By comparison, the rising cost of fuel was allocated a risk rating on the register of 16. Some practices that were identified as deficits in the manager's monthly audits, such as lack of regular formal supervision for all staff members was not included on the risk register. The deficits reported on in detail under standard 2.3 of this report and noted in various records at the centre was given a risk rating of 3 on the risk register. This, alongside commentary that the toilets were blocking, and the system was not clearing. This issue, which had the real potential to impact on the health of young people and staff, had not been allocated a higher risk rating and had not been escalated to an extent that resulted in a positive resolution of the system. The registered provider must take immediate corrective action to devise and implement a robust risk management framework and to educate the management and staff teams in the area of risk. The registered provider must ensure that there are systems in place to effectively identify, assess and manage risk implementation of learning around risk.

| **Compliance with regulations** | |
|---|---|
| **Regulation met** | **Regulation 6** |
| **Regulation not met** | **Regulation 5** |

| **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** | **Not all standards under this theme were assessed** |
| **Practices did not meet the required standard** | **Standard 5.2** |

**Actions required**

- The proprietor must make the necessary structural changes to ensure that the internal management structure of this centre is appropriate to its size and purpose and function.
- Centre management must implement the necessary measures to evidence that there is a culture of learning, quality and safety in this service.
- The registered provider must take immediate corrective action to ensure that all operational policies and procedures are in line with current national standards. Senior management must put a plan in place for the prioritisation of the rollout of the policies and procedures to inform the staff team.
- The registered proprietor must implement the necessary changes to ensure that there is adequate oversight and governance of service delivery at this centre.
- The centre manager must ensure that there is adequate discussion of young people's risk planning documents at team meetings.
- The registered proprietor must ensure that a robust risk management framework, comprised of effective systems of identification, assessment and management of risk is realised at this centre.

**Regulation 6: Person in Charge**
**Regulation 7: Staffing**

**Theme 6: Responsive Workforce**

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

Inspectors found from a review of information provided, that workforce planning was discussed at manager's meetings and was a regular topic in communications between the centre manager and the operations manager, however this was insufficient to ensure that the matter was given the response it required. Inspectors found that although the centre was operating at full capacity of residents and had an assigned allocation of eight full time social care worker posts, it was understaffed at the time of this inspection. The centre was not functioning at a level that ensured it was meeting the identified needs of the young people in accordance with its stated purpose and function; nor was there apparent recognition that a young person had been placed in the centre three months prior that was aged outside of their purpose and function,

was much younger than the three other residents and therefore presented with vulnerabilities as a result. Inspectors noted from a review of young people's meeting records and through interviews with social workers, that young people had commented on staffing at the centre noting that there were not enough staff available to them at certain times, and that there were high numbers of staff working at the centre. Inspectors noted that in the month of December 2021 alone, there were twenty-one staff members listed in daily logs. This created a situation that did not readily contribute to continuity and stability of care for young people, nor did it appear to take on board the views of the young people in the centre experiencing this. Inspectors noted from a review of available records that there were several occasions on which staff worked a double sleepover shift. This should not be an accepted practice in the centre and must cease immediately as such.

During this inspection process, the operations manager and centre manager concurred that the staffing levels were less than adequate to meet the needs of the centre. The format of the manager's governance audits did not allow for a documenting of workforce planning for the centre or allow for this to be escalated as an issue to senior management within the audit itself. Whilst it was identified on the centre's risk register, as noted earlier in this report the content of the risk register was not appropriately updated. A need for increased staffing numbers had been identified during the summer of 2021 related to the placement of a young person with significantly complex emotional and behavioural needs. This was noted on the centre's risk register at that time and had been responded to by the provision of additional staff, including the use of agency staff from outside of this organisation. The centre's risk register, although reported as being updated monthly, still included this detail of additional staffing requirement for this young person in March 2022, although they had long since been discharged from the centre. Neither had the risk rating of the issue staffing on the centre risk register altered since its inclusion on the register. An increase in the risk rating assigned to staffing would have been appropriate and necessary to generate an appropriate response. However, as detailed under 5.2 of this report, inspectors found that the understanding of and response to risk was not adequate.

The operations manager stated that the need for additional staffing allocated to this centre had been escalated to the proprietor and recruitment campaigns were ongoing, this was documented in the centre's risk register also. There needs to be an increase in staff numbers, and this must be prioritised with immediate effect. This increase in staffing must come from fulltime employees and they ideally should be dedicated to working in this centre for a minimum specified period to create a stable

and cohesive staff team that can ensure the children in this centre experience stability. The proprietor must ensure that the recruitment and appointment of staff prioritises the needs of existing children being cared for within this and other centres.

Inspectors reviewed a large sample of the qualifications of staff members provided to them by the centre manager. Of the records reviewed, over half had a social care qualification. Inspectors noted that not all the qualifications provided by the staff member had been verified by the employer. Some staff had confirmation of attendance on a particular course, but this does not equate to verification of a qualification. This deficit had been identified in another inspection within this service in 2021. Centre management must ensure that copies of qualifications and verifications of those qualifications are secured for all staff files as a matter of priority.

A matter of discontent amongst identified members of the staff team was brought to inspectors' attention by the centre manager at the outset of this inspection and relevant records relating to the investigation of the matter, with supporting documentation was readily provided for review. Inspectors noted from a review of the information that the centre manager, who had sought HR advice from within the company and from an external expert, had followed the company's policy in relation to the conduct of such matters. Inspectors found however, that the matter was not effectively or well supported by external management in an appropriately responsive manner. Difficulties within the team had been openly discussed and documented at a team meeting in July 2021. These had been reviewed by the company's quality assurance and practice manager, but no action had been undertaken by them. At that time also, the centre was supporting a young person in placement that was experiencing a significant crisis, the centre was understaffed, and the manager was the sole person responsible for the delivery of formal supervision to the staff team. Deficits in completing scheduled supervision had been consistently highlighted by the manager in their monthly governance audits and by the quality assurance and practice manager in their audits. Formal supervision may have provided some measure towards intervening in and addressing this issue more robustly at that time. However, inspectors found that supportive measures that could and should have been implemented sooner, such as – support around the delivery of supervision; an audit of practices at the centre to ascertain accountability for delivery of professional practice in accordance with stated expectations; the delivery of a piece of training/information on code of conduct, professional responsibility, and accountability – had not been. The proprietor must ensure that a formal review of

this matter is undertaken, with any update of policy initiated as necessary, and learning delivered to the team.

Following the onsite inspection, the operations manager provided inspectors with a list of employee benefits that had been circulated within the company in March 2021. The list named 'maternity benefits', debriefing, immunisations, income protection after a specified period of 13 weeks post-illness, and personal accident cover amongst others. During interviews for this inspection, incentives of employment were not readily listed by those interviewed. Those that were briefly referenced were named in the context of not being of personal benefit and thus a personal incentive to individuals. Senior management had recently asked the centre manager to bring the matter of retention incentives to the staff team meeting for discussion. Amongst the suggestions put forward was that senior management have a greater/more frequent presence in the centre. The proprietor must put arrangements in place to promote staff retention and continuity of care for the young people in this centre.

There was a formal policy for the provision of on-call support outside of office hours. This responsibility was delegated to a manager and there was a specified list of reasons/situations that warranted the use of on-call. The on-call manager also acted as the Designated Liaison Person in the event of a child protection concern. Where a significant event (SEN) results in a staff member contacting on-call, the individual SEN will include this detail. On-call managers maintain their own records, and these are then included in a centralised record within the company.

| **Compliance with regulations** | |
|---|---|
| **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** | **Not all standards under this theme were assessed** |
| **Practices did not meet the required standard** | **Standard 6.1** |

**Actions required**

- The centre manager must ensure that the practice of back-to-back shifts ceases and only occurs in exceptional circumstances supported by risk management plans.

- The centre and operations managers must ensure that staffing deficits are appropriately risk rated on the centre risk register, and formally escalated as necessary.
- The dedicated staffing numbers for this centre must be increased to ensure that they are sufficient to meet the needs of the children living in the centre at all times and to meet the needs of the centre's statement of purpose.
- Centre management must ensure that copies of qualifications and verifications of those qualifications are secured for all staff files as a matter of priority.
- The proprietor must ensure that a formal review of the matter that contributed to difficulties within the staff team is undertaken, with any learning delivered to the team.
- The proprietor must put valued arrangements in place to promote staff retention and continuity of care for the young people in this centre.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| **2** | Centre management must identify a realistic completion date for the painting of the outside of the property. | The external painting of the property was undertaken and completed on 14th April 2022. | Centre management and senior management will monitor routine maintenance requirements to ensure they are completed as necessary. |
| | Centre management must ensure that there are appropriately detailed records of fire drills and maintenance issues, including completion dates, maintained at the centre. | The Centre manager will ensure that the details of fire drill records and maintenance issues are maintained inclusive of completion dates. Reviewed with the care team at the staff meeting on April 26th, 2022. | Centre management will ensure effective governance and oversight of recording of all fire drills and maintenance issues to ensure they are appropriately recorded. |
| | The proprietor must ensure that a review is undertaken by a qualified engineer/fire safety officer to verify that the fire alarm and emergency lighting system is fully operational following the identification of the issues detailed here. | The fire alarm and emergency lighting system is fully operational and it was repaired by a qualified technician. Any faults on the fire alarm would be identified on the systems control panel. The system is serviced annually with the next service scheduled for May 4th 2022. | Centre Management will ensure that certificates are issued for any repairs to the fire alarm systems to evidence it is fully operational and in working order in addition to the annual servicing. |

| | | | |
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| | The proprietor must address the deficits related to plumbing and provide evidence of this to inspectors. | Completed. New system installed in two bedrooms on 5th April 2022. An external company completed report on 11th April 2022 (report completed and forwarded to inspector following same). Following the replacement of two new toilets there have been no further issues or actions required as all is in working order. | If any issues emerge with the plumbing system centre management will promptly escalate these to the registered provider for immediate action to be taken. |
| | The proprietor must put in place the necessary procedures for managing risks to the health and safety of children, staff, and visitors in this centre. This should include a clear and effective risk escalation system that demonstrates knowledge of health and safety risks. | The care team complete defect reports and escalate to centre management. The centre manager and operations manager will maintain oversight of health and safety for the centre. The centre manager will notify senior management of any issues in relation to H&S and any maintenance defects within the centre. The centre manager will forward all maintenance request to the OM on a weekly basis whereby tasks will be assigned to the appropriate maintenance personnel with timeframes for completion. Any issues arising will be escalated to the registered provider by the centre manager. Certificates/ Reports provided by | The centre manager and operations manager will maintain oversight of health and safety for the centre. Centre management will escalate maintenance as required to ensure emergency and urgent requests are addressed in a timely manner. |

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| | | maintenance personnel will be stored in the centres health and safety records. | |
| **5** | The proprietor must make the necessary structural changes to ensure that the internal management structure of this centre is appropriate to its size and purpose and function. | The registered provider has recruited two regional managers for the service to commence in June 2022. There will be a dedicated regional manager to oversee the centre and support the centre manager in the day-to-day operations of the centre. The RM will have greater onsite presence to be available to the centre manager and care staff and YP living in the centre. | The RM will be available to the centre manager to provide greater support on an ongoing basis to ensure consistent governance and oversight of the centre. |
| | Centre management must implement the necessary measures to evidence that there is a culture of learning, quality and safety in this service. | The centre manager will ensure that regular discussion and evidence of discussions had is recorded from team meetings, supervision sessions, handovers, house meetings and MDTM's to promote a culture of learning, quality and safety in the centre. More focus will be put on discussion regarding policies and procedures and more open discussion regarding learning from events with the young people. Immediate and ongoing. | Centre management will ensure that there is sufficient and appropriate recording of decisions and discussions to evidence that there is a culture of learning, quality and safety. This will be supported and monitored by the senior management team. |
| | The registered provider must take | The P&P document will be reviewed to | Centre manager and senior management |

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| | immediate corrective action to ensure that all operational policies and procedures are in line with current national standards. Senior management must put a plan in place for the prioritisation of the rollout of the policies and procedures to inform the staff team. | ensure that all operational policies and procedures are in line with current national standards. Changes within the policies will be reviewed with the care team at TM level- to be completed by 30th June 2022. | will review on an annual basis or as required to ensure that they remain in line with current national Standards. |
| | The registered proprietor must implement the necessary changes to ensure that there is adequate oversight and governance of service delivery at this centre. | The registered provider has recruited two regional managers for the service to commence in June 2022. There will be a dedicated regional manager to oversee the centre and support the centre manager in the day-to-day operations of the centre. The RM will have greater onsite presence to be available to the centre manager and care staff and YP living in the centre. | The RM will be available to the centre manager to provide greater support on an ongoing basis to ensure consistent governance and oversight of the centre. |
| | The centre manager must ensure that there is adequate discussion of young people's risk planning documents at team meetings. | This was reviewed with the care team by centre management at the team meetings in March and April. Open discussion and learning occurred in relation to same. Risk planning and risk assessment will be added as a standing agenda at team | Standing agenda item on team meetings monthly with care team. Will be reviewed with staff individually in supervision as required. |

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| | | meetings going forward. Immediate and ongoing. | |
| | The registered proprietor must ensure that a robust risk management framework, comprised of effective systems of identification, assessment and management of risk is realised at this centre. | A review of the services Risk Management Framework will take place at the management meeting in May 2022. Any actions identified at this review will be implemented. Immediate and ongoing. | Centre management and senior management will monitor risk management for this centre and address any deficits as required with the centre. |
| **6** | The centre manager must ensure that the practice of back-to-back shifts ceases and only occurs in exceptional circumstances supported by risk management plans. | The centre manager will ensure that back-to-back shifts do not occur and if they do occur this will only be in exceptional circumstances and supported by appropriate risk management plans. Immediate and ongoing. | This will be closely monitored by centre management; back-to-back shifts will not be permitted. |
| | The centre and operations managers must ensure that staffing deficits are appropriately risk rated on the centre risk register, and formally escalated as necessary. | Risk register has been reviewed to adequately rate the staffing deficits. All staffing issues will be escalated to senior management and the registered provider as required. Immediate and ongoing. | Risk register will be reviewed on a regular basis and shared with senior management. This will be monitored monthly by centre management. |
| | The dedicated staffing numbers for this centre must be increased to ensure that they are sufficient to meet the needs of | Recruitment is ongoing and staffing is being reviewed by the operations manager, HR department, centre manager and | Workforce planning will be kept active by HR, operations manager and centre manager to ensure sufficient staffing |

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| | the children living in the centre at all times and to meet the needs of the centre's statement of purpose. | operations manager have recruited additional staff specific to this centre, which ensures that the dedicated staffing numbers are increased to meet the needs of the young people- WTE: 9.2, Relief: 5. | numbers are in place. |
| | Centre management must ensure that copies of qualifications and verifications of those qualifications are secured for all staff files as a matter of priority. | A review of all personnel files was completed by the centre manager and HR department. All qualifications have been secured for staff assigned to this centre with the exception of one staff member at present. This is being followed up by the HR department. | The operations manager will ensure that all staff commencing work within the service have the appropriate qualifications held on their personnel files. |
| | The proprietor must ensure that a formal review of the matter that contributed to difficulties within the staff team is undertaken, with any learning delivered to the team. | Centre manager and senior management will review this matter and communicate learning to the care team in relations to the organisations code of conduct and grievance procedures. This will be completed by June 30th. | The centre management and senior management will monitor staff relations to ensure any issues are appropriately addressed in a timely manner. |
| | The proprietor must put valued arrangements in place to promote staff retention and continuity of care for the young people in this centre. | There are a number of arrangements in place to promote staff retention. This can be evidenced by the fact that staff have been promoted internally, length of | The findings of the survey will be reviewed by HR and the registered provider, and any possible actions will be implemented in a consultative manner with staff. |

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| | | service, and a member of staff interviewed for this inspection is a registered TCI instructor for the service. The HR consultant has furnished an anonymous survey to staff to identify the areas that could be improved upon to promote staff retention and employee satisfaction. | |