An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 007

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Novas Initiatives**
Registered Capacity:	**6 young people**
Type of Inspection:	**Announced (remote)**
Date of inspection:	**7th and 8th January 2021**
Registration Status:	**Registered from 13th March 2021 to the 13th of March 2024**
Inspection Team:	**Linda Mc Guinness**
Date Report Issued:	**4th March 2021**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in 2003. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from the 13th March 2018 to the 13th March 2021.

The centre was registered to accommodate six young people of both genders from age twelve to seventeen years upon admission. It provided medium to long term care placements for separated young people seeking or granted asylum. The model of care was described as a person centred, holistic approach where young people were met with unconditional positive regard. It was based on Maslow's hierarchy of needs and sought to meet basic, social emotional educational developmental and religious needs. There was a strong focus on preparation for leaving care. There were four young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.1, 1.2, 1.3, 1.4, 1.5, 1.6
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make. Due to the emergence of Covid-19 this review inspection was carried out remotely. This inspection was carried out through a review of documentation and a number of telephone interviews.

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 22nd January 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 5th February 2021. This was deemed to be satisfactory and the inspection service received an updated suite of policies and procedures and a commitment to implement all actions set out in the CAPA.

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: 007 without attached conditions from the 13th March 2021 to the 13th of March 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 7: Staffing
Regulation 9: Access Arrangements
Regulation 11: Religion
Regulation 12: Provision of Food and Cooking Facilities
Regulation 16: Notification of Significant Events

Theme 1: Child-centred Care and Support

Standard 1.1 - Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child.

The inspector found that the care provided in the centre was child focused and promoted the rights of young people as set out in Irish law and in the United Nations UN Convention on the Rights of the Child. There was evidence that young people were informed of their rights upon admission to the centre and that this was further explored with them through keyworking and other forums. However, it is recommended that the rights of young people are more specifically outlined in the young person's information booklet. This booklet would benefit from review from a design, layout and language perspective and should include more specific information relating to issues which might impinge of their rights such as room searches. Special efforts were made to ensure that young people understood and were facilitated to participate in their care planning based on their age, level of understanding and communication skills. Translators were sourced without delay to support this process where English was not a primary language for young people. Review of documentation and questionnaires evidenced that there was a culture of respect in the centre and that young people's views and opinions were valued. The inspector found that the centre was an excellent example of how diversity, equality and inclusivity was managed on a day to day basis.

Review of young people's care and placement plans evidenced that planning for young people took account of their specific rights. Young people were supported to celebrate religious events. The staff rota was adjusted where required to assist young people to adhere to religious obligations such as Ramadan. Specific dietary requirements such as the provision of Halal food were catered for and a weekly meal planner was devised with input from young people.

Standard 1.2 - Each child's dignity and privacy is respected and promoted.

The inspector found through review of centre documents, questionnaires returned by management, staff and young people that the dignity and privacy of young people was respected. Each young person had their own room where they could spend time alone and where their belongings could be safely stored. Where room checks were implemented in the interests of health and safety these were as a result of a risk assessment. There could be better evidence that this process was linked to the risk management framework and was appropriately recorded and reviewed. Young people were made aware of the rationale of such measures through individual work and key working. The booklet which was provided to young people upon admission to the centre referenced what the centre records about them, the reasons why and with whom information is shared. This was followed up further by key workers after young people moved into the centre. The staff team collated photos and memorabilia of each young person's time in the care in the centre and they were provided with this when they moved on from the centre as a record of their experiences and relationships while living there.

Standard 1.3 - Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.

The inspector found that the person-centred care which was one of the core aspects of the model of care was implemented in practice. Young people were consulted about their plans and about aspects of the day to day running of the centre. Social workers confirmed in interview with the inspector and through questionnaires that young people contributed to discussions and decision making through the care and placement planning processes. Young people's meetings were held regularly and these were then discussed at team meetings and where appropriate feedback was given back to them. The inspector was informed that mealtimes were shared experiences where informal discussions took place.

There was a key working system in place whereby allocated staff co-ordinated the placement planning with a young person and their social work department in line with the needs set out in their care plan. Where possible, young people were given choice of who would key work with them. The keyworker also liaised with other professionals involved in the care of the young person. Young people, social workers and the team described positive relationships between young people and staff.

Minutes of care plan meetings, monthly progress reports and placement plans all pointed to evidence that young people were provided with information suitable to their level of understanding to facilitate them to participate in setting goals and in decision making. Young people who responded to questionnaires were happy with all aspects of care provision and specifically said they were listened to by the staff team.

Young people were informed what information was being held about them. The inspector was informed that while young people knew they could access their information they often chose not to. There was a lack of evidence that young people were afforded with opportunities to read and contribute to their care files and a system should be implemented to ensure that this in place.

Young people's meetings took place regularly and were a forum where their opinions could be expressed about aspects of daily living and the shared living space. The items discussed here were then explored at team meetings and there was evidence of appropriate follow up with the group or individual young people. It was evident that there was a culture of openness and that the management and team were available to young people. There was a system in place to conduct exit interviews with young people who have left the service. The inspector reviewed samples of these documents in which each young person spoke highly of the support received.

There was evidence that young people were provided with information about advocacy groups such as the Children's Rights Alliance and Empowering people in Care (EPIC) who could support them if required. Support was provided to assist them to access these services.

Standard 1.4- Each child has access to information, provided in an accessible format that takes account of their communication needs.

Where possible young people were provided with information about the centre prior to their admission and they had an opportunity to visit and ask questions. As referenced previously, the information booklet which is provided at the outset of placement required review and it would be useful to involve young people in this process. Each young person in this centre at the time of inspection was of an age where aftercare planning was commencing and being progressed. They were provided with information about supports available to them. There was evidence that age appropriate communication took place with young people to ensure that they could reflect on their personal circumstances and be included in the planning process. Young people were provided with a version of the National Standards for

Children's Residential Centres, 2018 (HIQA) and staff spent time with them to assist them to understand the content and implications for them.

Standard 1.5 - Each child develops and maintains positive attachments and links with family, the community and other significant people in their lives.

While staff and management absolutely recognised the importance of families, this centre was specific in that it provided care to young people who are separated from their families and seeking asylum in Ireland. Therefore, it was often the case that there was no contact with families or they were not involved in the care planning for young people. There was a dedicated social work department for this cohort of young people, and they worked with them and the Red Cross to locate missing family members or to apply for reunification of families here in Ireland. Family contact was supported and encouraged where possible and this was managed closely in collaboration with the supervising social work departments. Young people had been facilitated to spend periods of time in other countries with significant family members to maintain established relationships. Where direct contact with parents, siblings and significant others was not possible young people were facilitated to keep in contact by other means. The inspector found that as well as encouraging and supporting integration young people were supported to maintain links with their own cultural communities here in Ireland if they chose to. It was evident across centre records that young people were facilitated to engage in interests and hobbies in the local community and they had participated in local sporting clubs for example, where their talents were supported and encouraged. Young people's special occasions such as birthdays or achievements were celebrated as part of the shared living space and were marked as important occasions in their lives.

Young people had age appropriate access to telephones, internet and other forms of communication. There was evidence that risk assessments informed any limitations on these in the interests of safety, if required. It is recommended that this is included on the centre risk register for monitoring and tracking purposes. The inspector found that planned pieces of education took place with young people to ensure that their access to information on line was managed safely.

Standard 1.6 - Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

There was an updated policy in respect of complaints, compliments and comments. Young people were informed that they had a right to complain and how to do so. The inspector found that while there was evidence that young people were consulted and listened to through the course of their placement in the centre, improvements were required in the recording and management of complaints. The team demonstrated that they listened when young people expressed dissatisfaction about an aspect of their care or service provision. Where complaints were recorded there was evidence that they were managed, concluded and the outcome held on the young person's file. Notwithstanding that, the inspector found that there were a number of issues which should have been dealt with through the complaints process but were not recorded and managed as such. As a result, this hindered effective monitoring of complaints at a senior management level and, if not reported, could not be tracked for emerging themes or patterns. In one instance a young person should have been afforded the opportunity to make a complaint about a Tusla issue through the Tusla 'Tell Us' policy. The complaints policy as it stood, conflated the centre policy with the Tusla policy and required review to ensure clarity. The centre manager must ensure that all staff are clear about the internal and external complaints policies and how to implement it in practice. The issue in respect of the recording and management of complaints was also an area requiring attention in the 2020 inspection of this service and must be addressed as a matter of urgency.

There was no evidence to date that young people's experience of using the complaints process was explored with them for organisational learning purposes and this must be implemented as part of a robust complaints process.

Compliance with Regulations	
Regulation met	**Regulation 7** **Regulation 9** **Regulation 11** **Regulation 12** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 1.1, 1.2, 1.3** **Standard 1.4, 1.5**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**None identified**

Actions required

- The registered provider must ensure that the complaints policy is revised to ensure clarity for staff and young people. Complaints relating to Tusla service provision should be processed through the Tusla 'Tell Us' complaints policy.
- The registered provider must ensure that all complaints are recorded, managed, reviewed and that young people and their social workers are informed of the outcome.
- The registered provider must ensure that there is an effective system in place to review to review complaints for learning purposes. Feedback from young people about the process of making complaints should be included.

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

Theme 5: Leadership, Governance and Management

Standard 5.1 - The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

Inspectors found that mechanisms to ensure that the centre was operating in compliance with regulations and national standards were not in place. This matter was identified as requiring priority attention in the 2020 inspection of this service and the corrective and preventative action plan made commitments to address this issue. Notwithstanding that this was against the backdrop of organisational changes and the emergence of Covid-19 pandemic, the registered proprietor must ensure that all issues requiring action from inspection processes are fully completed in a timely manner.

Notwithstanding that the emergence of the Covid-19 pandemic had resulted in necessary changes to service provision and delivery the inspector found that there were inadequate arrangements in place to ensure that there was external oversight of the centre's care practices and operational procedures. New legislation such as GDPR and National Standards for Children's Residential Centres, 2018 (HIQA) had not been incorporated into centre policies in a timely manner. The process had begun in 2019 and was understandably delayed by the pandemic but was still on-going at the time of this inspection with only some of the policies having been revised in line with updated standards. As a result, this impacted the management capacity to monitor practice and performance effectively against the relevant legislation and national standards. A number of issues arose throughout this inspection process that were not compliant with national standards and these had not been highlighted through internal monitoring or quality assurance processes. Some of these were identified as requiring action or priority attention in previous inspections.

The inspector noted some improvements in that staff during this inspection demonstrated an understanding of relevant policies relating to safeguarding and child protection. Where policies had been revised and updated there was evidence that staff were consulted and that there was reflection and discussions about these in team meetings and supervision processes.

The registered proprietor must ensure that the centres policies and procedures are reviewed and updated and aligned with the National Standards for Children's Residential Centres, 2018 (HIQA) and other relevant legislation. The registered proprietor must ensure they review new and existing legislation and national policy on a regular basis to determine how it impacts on practice and to address any gaps in compliance.

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.

Through staff interviews and a review of records the inspector was informed that the centre was generally well managed, that the manger was approachable and accessible and had a clear focus on positive outcomes for young people. There was some evidence that while management provided good guidance and support that they would benefit from skills development in the areas of leadership and team management. Feedback from the staff team also indicated that more clarity could be provided in respect of roles and responsibilities of the management team. There was also a recurring theme of communication difficulties arising through inspection interviews and review of questionnaires. There was no evidence that these issues had been highlighted or addressed internally through quality assurance processes or through line management supervision.

Supervising social workers who were interviewed and responded to questionnaires were satisfied that the centre was managed well and that the manager and team worked collaboratively with them to provide a high standard of care.

Inspectors found that there was an appropriate emphasis on quality and safety of care provision in team meetings and through supervision records. Nevertheless, this was less evident at senior management level with a lack of oversight, formal auditing and records of management meetings. While a culture of learning was evident through review of a range of records which included significant event review group, team meetings and training records this lack of auditing in any structured way indicated a requirement for more clearly defined governance arrangements and structures.

The centre manager had been in post for the past twelve years. They were present in the centre five days a week and had overall responsibility and accountability for the

delivery of care. The centre manager did not have the relevant qualification as required and they and the CEO informed the inspector that options were being explored for them to up-skill and that they and the organisation were committed to the process. At the time of this inspection there were no formal mechanisms in place for governance reports to be provided to line managers or up to the board of management. The manager reported directly to the CEO who had visited the centre on occasion although this and the presence of the quality assurance manager on site was limited by the Covid-19 risk management plan. There was a service level agreement in place with the Child and Family Agency.

As mentioned previously, the inspector found that the work to align the centre policies with the National Standards for Children's Residential Centres was significantly delayed since they were published in 2018 and this must be completed as a matter of urgency. On-going review of policies and procedures and regulations must be incorporated into governance management.

Since the last inspection in January 2020 the organisation had implemented a policy and a risk management framework as required. These included a matrix and supporting structures for the identification, assessment and management of risk. It was a comprehensive system however, the inspector found that it required some review to ensure effective implementation and oversight. There was a risk register in place however this primarily identified organisational risks and was only reviewed once or twice annually. The policy did not clearly outline risk escalation processes. Staff members in interview did not demonstrate familiarity with the centre's risk framework and the matrix in place was not utilised to identify and manage risk within the centre. The inspector noted a number of issues which should have been managed through the risk management framework and were not. The implementation of the framework within the centre was not in line with the policy governing risk management and this was not highlighted through auditing or other governance processes.

There was evidence that pre-admission risk assessments were carried out prior to the young people's admission and there was evidence that individual risks were assessed and reviewed on an on-going basis. There was an adequate on call system in place to support staff during evenings and weekends and other times when management were not on site in the centre. Staff expressed frustration that management presence in the centre was reduced due to the Covid-19 risk management plan.
Inspectors assessed the organisation's response to the management of risks posed by the Covid 19 pandemic. Inspectors reviewed the policies, procedures and

contingency plans in place. These were frequently updated in accordance with guidance from National Public Health Emergency Team (NPHET) and government guidance. A robust cleaning schedule and procedures to manage visitors to the house were in place. These were discussed in staff supervision. There were adequate supplies of cleaning equipment, anti-bacterial products, and personal protective equipment on site. Team and management meetings were taking place remotely to ensure safety.

The centre had an internal management structure appropriate to the purpose and function of the centre however no quality assurances processes/audits had taken place during 2020 either remotely or on site. One of the social care leaders assumed responsibility for the centre in the manager's absence. When the centre manager delegated tasks to other staff members a written record was maintained of tasks and decisions made during that period.

Standard 5.3 - The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre had a written statement of purpose which described the model of service care. The statement outlined the aims and objectives of the service, the range of services, the arrangements for the wellbeing and safety of young people and the details of management and staff team. The statement was not dated, there was no set review date it did not yet outline the key policies in place to support safe care. The centre manager in conjunction with senior management must ensure that the statement of purpose is updated, reviewed and evaluated to provide assurance that the centre is operating in line with the statement of purpose. At the time of this inspection consideration was being given to include 'trauma informed care' in the model of care and to put supporting structures in place for this, such as training and clinical consultation. This would be a positive move for young people who have experienced significant trauma. The framework would be a good fit and very much support current model of care.

Staff members displayed a good understanding of the model of care through inspection questionnaires and interviews. It was evident that the current statement of purpose was reflected in the day-to-day operation of the centre. The centre had written information about its operations that was in an accessible format for the young people. While it required some review the inspector noted that it was also translated into other languages to facilitate young people who did not speak English. There was evidence that key workers and managers had continued to communicate

the information about the centre to the young people after their admission through individual work. Young people were generally separated from families and had no contact. Where contact was established the social work department communicated information about the centre to family members.

Standard 5.4 - The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

There was evidence that the centre manager monitored the daily planning and delivery of care to young people in the centre. There were new systems in place to facilitate external managers to read and sign off on significant event notifications and complaints. Expansion of this system to allow for remote access to all centre records was being explored at the time of inspection.
While there was periodic attendance at team meetings and significant event review groups there was a lack of evidence that the external line manager and quality assurance manager monitored the quality of care in the centre through audits, action plans, or visits to the centre to meet with young people and staff. This action was identified as requiring priority attention following the 2020 inspection process and report and remains outstanding. Improvements were required in the content and records of internal and external management meetings to evidence that a robust governance system is in place.

The centre manager maintained a complaints register in the centre to allow for tracking and identification of complaint trends.
There was a significant event review group in place which was intended to meet the requirement to monitor and analyse incidents and complaints. Some complaints that took place in the centre were not recorded and therefore were not analysed and reviewed at this forum. This process of oversight would only be effective once the issues relating to recording of all complaints are addressed.

The centre management were aware of the requirement for the registered provider to conduct an annual review of compliance of the centres objectives to promote improvements in work practices and to achieve better outcomes for young people. While an annual statement of compliance was signed and provided to Tusla there was no formal review of service provision against the centre's set objectives. It is recommended that an annual service improvement plan is drawn from processes such as centre audits, inspection processes and the annual review.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 5.1** **Standard 5.2** **Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The registered proprietor must ensure that all issues requiring action from inspection processes are fully completed in a timely manner.
- The registered proprietor must ensure that the centres policies and procedures are reviewed and updated and aligned with the National Standards for Children's Residential Centres, 2018 (HIQA) and other relevant legislation.
- The registered proprietor must ensure they review new and existing legislation and national policy on a regular basis to determine how it impacts on practice and to address any gaps in compliance.
- The registered provider must ensure that the centre manager is supported to up-skill and attain a qualification relevant to their role in management.
- The registered provider must review the risk management framework to ensure that it is operational in respect of the identification, assessment and management for risk in the centre. It should include a risk escalation process.
- The implementation of the risk management framework must be subject to regular external review as part of governance arrangements for the centre. Evidence of this must be included in senior management meetings.
- The statement of purpose must be dated, include a review date and specifically outline the key policies in place to support safe care.
- The registered provider must ensure that there are robust measures in place to monitor and oversee the quality, safety and continuity of care and that auditing takes place to assess compliance with the relevant regulations and national standards. Accountability for good governance must be evident in senior management meetings.

- The registered provider must ensure that there is an annual review of compliance with the centre's objectives and that a service improvement plan is implemented to promptly address any deficits.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The registered provider must ensure that the complaints policy is revised to ensure clarity for staff and young people. Complaints relating to Tusla service provision should be processed through the Tusla 'Tell Us' complaints policy.	A new version of the complaints policy is now available in the centre after being reviewed and approved by the Head of Quality. The policy has been annexed to the Novas' Complaints Policy. The policy shall be discussed with staff at the next team meeting on February 18th, to ensure that everybody in the centre have a clear understanding of it. Key workers shall be advised to discuss complaints with the young people in order to ensure they too understand how to make complaints and use TUSLA "Tell Us" complaints policy.	The complaints policy shall be reviewed in January 2022.
	The registered provider must ensure that all complaints are recorded, managed, reviewed and that young people and their social workers are informed of	All complaints are being recorded and managed via the Sales Force platform, which is currently being updated to better reflect the nature of complaint, review and outcomes. The findings, outcomes and	Once every year the complaints section of the IT platform shall be reviewed to ensure that it is fully functional and reflects the needs of the service. All complaints are being managed by the centre's manager and

	the outcome. The registered provider must ensure that there is an effective system in place to review to review complaints for learning purposes. Feedback from young people about the process of making complaints should be included.	learnings from complaints shall be communicated to the young people, staff and social workers in timely fashion. The IT system generates automatic notifications to the centre manager and the Head of Quality. These are addressed by the centre manager in a timely manner, feedback given to the young people and staff via set meetings. If a complaint requires the attention of the Head of Quality, they shall follow procedures to address these as soon as possible.	Head of Quality, they are discussed and reviewed every quarter or on a need to be basis. It has been established in a meeting (4th February 2021), between the centre manager and senior managers responsible for the governance of the centre that review meetings shall take place every quarter where matters arising from complaints, incidents and risk management are being analysed, outcomes and learning discussed and feedback to all parties concerned is given by the centre manager. Dates for these meetings have been agreed for the whole year with the next meetings set for May 4th, August 3rd, and November 2nd.
5	The registered proprietor must ensure that all issues requiring action from inspection processes are fully completed in a timely manner.	The centre manager has met with senior managers within the governance arrangements and all the aspects emerging from our last inspection have been discussed and plans for improvements have been agreed upon. This will be an on-going process whereby the implementation	Rigorous and effective plans have been established during the centre and senior managers meeting from February 4th and the implementation process shall be monitored and reviewed at manager's meetings in the future, supervisions, and open communication at all levels.

		of recommendations will be reviewed at senior managers meetings. Learning and improvements shall also be communicated to staff and the young people.	
	The registered proprietor must ensure that the centres policies and procedures are reviewed and updated and aligned with the National Standards for Children's Residential Centres, 2018 (HIQA) and other relevant legislation.	Policies pertaining to all eight themes in the HIQA National Standards for Children's Residential Services have now been completed and approved by the Head of Quality. The policies have been forwarded to TUSLA in support for the centre's application for registration.	All policies are subject to review once every year with a deadline set for January 2022.
	The registered proprietor must ensure they review new and existing legislation and national policy on a regular basis to determine how it impacts on practice and to address any gaps in compliance.	The centre manager shall be responsible to keep up to date with any changes in legislation, establish and maintain open communication with TUSLA and update senior managers on any relevant changes in legislation. Senior managers shall advise on any required action in timely fashion so that any changes required at operational level are implemented without delay.	Any arising issues from changes in current legislation shall be communicated, analysed, and required actions are agreed in order to keep the centre at a high standard in line with the legislation. The manager shall present up to date feedback from communication with TUSLA at senior managers meetings quarterly. The staff team shall also be informed of any changes and required actions.

	The registered provider must ensure that the centre manager is supported to up-skill and attain a qualification relevant to their role in management.	Novas is committed in supporting the manager to up-skill and a relevant management course is being currently sought.	It is our commitment that the manager shall be enrolled in a relevant management course during the current year.
	The registered provider must review the risk management framework to ensure that it is operational in respect of the identification, assessment and management for risk within the centre. It should include a risk escalation process.	The IT platform shall be updated to include management of risk, inclusive of identification, assessment, and review as part of an on-going process. The system shall also reflect residual risk and actions required as well as the risk escalation process.	Management of risk shall be brought forward to the Senior Management Team and shall be included on SMT's meeting agendas.
	The implementation of the risk management framework must be subject to regular external review as part of governance arrangements for the centre. Evidence of this must be included in senior management meetings.	The review of the risk management framework is deemed as a priority for the board and shall become an on-going process which shall be constantly monitored via the Sales Force platform to ensure that matters relating to risk management are addressed in timely fashion.	Review of the risk management framework shall be included on the senior managers meetings quarterly on the dates stated above. The centre manager and the Head of Quality shall also meet separately in order to update the centre risk register on regular basis with the first meeting set on March 2nd.
	The statement of purpose must	The statement of purpose shall be updated	The statement of purpose shall be reviewed

	be dated, include a review date and specifically outline the key policies in place to support safe care.	by the manager in order to incorporate the Trauma Informed Care framework which shall also become part of the model of care. This piece of work shall be completed by the end of February and presented to senior management for approval. Thereafter the staff team shall be informed of the changes via team meetings and it will also become part of the supervision process. Meanwhile, all staff in the centre shall undergo up to date training in Trauma Informed Care.	along the current policies in the centre by January 2022.
	The registered provider must ensure that there are robust measures in place to monitor and oversee the quality, safety and continuity of care and that auditing takes place to assess compliance with the relevant regulations and national standards. Accountability for good governance must be evident in senior management meetings.	The IT platform shall also be updated with robust system that monitors the quality and safety aspects of the care provided. This process is now on-going. The Head of Quality shall carry out audits twice every year.	It has been established at senior managers meeting on February 4th that for 2021 the Head of Quality shall complete a desk audit on April 6th followed by an onsite audit for October 6th, 2021.

	The registered provider must ensure that there is an annual review of compliance with the centre's objectives and that a service improvement plan is implemented to promptly address any deficits.	Via constant monitoring of the centre's care practices, regular review of complaints and incidents and bi-annual audits we will generate sufficient data to reflect any deficits which will analysed in order to implement a robust improvement plan. The staff team will be informed of improvement plans in timely fashion so that changes identified are being implemented without delay.	At the senior management meeting of the last quarter of the year all findings from constant monitoring and review of care practices in the centre, shall be discussed with the focus on learning and future planning on how to implement any changes identified, address deficits and ensure that the centre is operating in compliance with current legislation.