An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 018

Year: 2019

Inspection Report

Year:	**2019**
Name of Organisation:	**Kellsgrange Children's Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection	**28th November 2019, 29th November 2019 & 12th December 2019**
Registration Status:	**With attached conditions from 11th April 2018 to the 11th April 2021**
Inspection Team:	**Joanne Cogley** **Linda McGuinness**
Date Report Issued:	**28th April 2020**

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 2015. At the time of this inspection the centre was in its second registration and was in year two of the cycle. The centre was registered without attached conditions from 11th April 2018 to the 11th April 2021.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was described as being built on a relationship based model which re-affirms the importance of working relationships between social care workers and young people within a contemporary perspective.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors looked 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 worked with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 17th January 2020 and to the relevant social work departments on the 17th January 2020. 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 24th January 2020. This was not deemed to be satisfactory and the inspection service did not receive evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre was not in compliance 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: 018 with attached conditions to the centres registration under Part VIII, Article 61, (6) (a) (I) of the Child Care Act 1991: There must be no further admissions of a young person to this centre from the 11th April 2018 to the 11th April 2021 with a review date of the 31st May 2020 for attached conditions.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

Inspectors reviewed the child protection policies in place and found these to be compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017. The centre also had a child safeguarding statement along with a supporting letter of compliance to say that this had been reviewed and approved by the Tusla Child Safeguarding Statement Compliance Unit. The centre had recently developed a policy on young people's access to electronic communication to safeguard the young people from possible exploitation on the internet and social media. The centre also had a bullying and harassment policy in place to support and guide their work.

Staff had received appropriate education and training regarding recognising and responding to allegations of abuse at induction stages of employment. Staff training records evidenced that each staff member had completed training in the Tusla E-Learning module: Introduction to Children First, 2017. The centre was yet to complete training with the staff team relating to the organisations policies on safeguarding and child protection. Despite the above training being evidenced, both the centre manager and staff members interviewed could not demonstrate awareness or understanding of this in practice. Staff members were not aware of who the designated liaison person (DLP) was or what the role of the DLP was. Staff members were also not aware of their role as a mandated person. There was limited knowledge of the Tusla portal and the correct procedure to be followed should a disclosure of abuse be made. Child protection and safeguarding was not evidenced as a recurring item on team meeting or management meeting agendas. It is essential a re-training is completed with the entire staff team including the centre manager to ensure they have the appropriate knowledge and understanding to manage a disclosure or a reasonable ground for concern should one arise. The centre manager did not keep a child protection register to allow for tracking of concerns and this is something which must be implemented. At the time of inspection neither the centre manager nor the registered provider had a mechanism in place for auditing child protection protocols and safeguarding mechanisms. The registered provider must ensure they implement

a governance tool for oversight of child protection protocols and safeguarding mechanisms.

The centre had a number of policies in place to ensure safeguarding and one aspect of this was their recruitment policies. Inspectors noted from review of staff personnel files that the centre's recruitment policy was not followed and the current recruitment systems being utilised were not robust in terms of safeguarding. The centres policy highlighted that an interview panel would comprise of an independent chairperson and no less than two interviewers. Interview notes were not present on file for review, but during interviews with staff members inspectors were informed that some had been interviewed by only one person with no formal structure noted. Inspectors also found that appropriate vetting mechanisms had not been implemented. Seven personnel files were reviewed, four of these did not have references from their most recent employer. There were also a number of references that were testimonials from friends or family members. There were no mechanisms for verbal verification of references and a template must be devised for this process. Dates of appointment were not clearly evident for staff members and in two instances staff members started work prior to all of their references being completed. Inspectors found a number of significant disclosures on garda vetting files and there was no evidence of corresponding risk assessments to ensure safeguarding measures were implemented around these disclosures. The centre's policy on recruitment highlighted that all vetting mechanisms must be completed prior to taking up employment. The registered provider must ensure policies are followed and appropriate safeguarding measures are in place and address the current issues in relation to garda vetting.

Placement plans and care plans for the young people had taken into account their individual areas of vulnerability and the need to keep them safe. Inspectors found that there were age appropriate programmes in place to support young people in the development of self-care and protection skills. From review of social work questionnaire, it appears there is a strained relationship with one social work department that could be improved with more effective communication from the centre. Inspectors did not find evidence of feedback being received by the unit from social workers or parents.

The centre had created pre-admission risk assessment template. This had been utilised for all admissions. This identified the behaviour and assigned a score to it. From review inspectors found risks identified and scored however there was no further identification on how the centre was proposing to manage the behaviour in

order to reduce the risk or the impact these behaviours may have on other young people. The registered provider must ensure the current pre-admission risk assessment is reviewed to account for preventative measures and impact of behaviours on other young people.
The centre did not have a policy on protected disclosures. Through interview staff were not aware of any external avenues should they have concerns relating to the registered provider. As the registered provider is present in the service on a daily basis it is essential a protected disclosure policy and procedure is developed and that staff members are aware of and familiar with the process. The centre manager and registered provider had recently managed a disciplinary procedure in relation to poor practice concerns however from review this appeared to have not been managed in line with policy nor in a timely manner. It is essential the registered provider ensure, as a matter of priority, a protected disclosures policy is developed and implemented, recruitment policies are adhered to and child protection training is completed with the staff team.

Standard 3.2

Staff had been trained in a recognised model of behaviour management and there was evidence of regular refresher training being completed. There was a policy in place that provided details to the staff team on the nature of and approaches to behaviour management in the centre. During interviews with staff, inspectors found there to be confusion amongst staff members and management in relation to the policy particularly around the area of the use of physical intervention. The registered provider must review the current policy in line with the information being provided to management and staff members and ensure the two correlate. The individual crisis management plans must also be reviewed in line with this to ensure staff members are aware of the current approaches in place. Staff members informed inspectors that the centre employed a 'no restraint' policy however there was no evidence of guidance being provided in these documents as to what to do should a situation escalate to violence. There was evidence of life space interviews occurring together with individual work being carried out with young people being supported to develop an understanding of their behaviour. Social workers for young people had provided sufficient pre-admission referral information to the centre.

The centre heavily relied on behaviour modification charts which included monetary rewards for engaging in key working sessions. This current behaviour management model appeared to be incongruent with the model of care (building relationships) being promoted by the centre. During interview with the organisation's

psychotherapist, they expressed they were unaware that this was in place and were not supportive of this practice. The registered provider must review the current approaches to behaviour management to ensure any approaches and interventions used are assisting young people to manage and alter their behaviours.

The current group living dynamics were strained due to one young person's behaviour. From interview with staff members this was considered to be behaviours of a bullying nature however this had not been affectively risk assessed and there was no evidence of safety plans around same. The centre had a policy in relation to bullying however there was no evidence to show this had been followed. The centre manager must ensure that all staff members are aware of how to manage bullying behaviours between residents within the centre.

There was no evidence of the registered provider regularly auditing and monitoring the centre's approach to managing behaviour that challenges. The registered provider must ensure an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.

Inspectors found at the time of inspection there was evidence of restrictive practice being used in the form of locking the door to the kitchen so that young people cannot access it at night time. During interview with the centre manager the rationale around same was provided to inspectors however this was not supported by policy or risk assessments. There was also no evidence of this being regularly reviewed within the centre or with social workers. There was no evidence of key working being done with the affected young person and no evidence of consideration given to the impact on the other young people. The centre manager must ensure any restrictive practice is risk assessed and regularly reviewed together with evidence of key working around same in an attempt to minimise behaviours.

Standard 3.3

Inspectors found that parents and social worker feedback was evident through care plan reviews however the director must ensure that the centre has its own mechanisms in place for parents and social workers to provide feedback directly to them for learning and improvement purposes. There was limited evidence to show feedback or consultation with young people in relation to any concerns or areas for improvement.

The centre had a policy on the notification, management and review of significant events and it was noted significant events were being reported in a prompt manner to the appropriate people.

The centre conducted a significant event notification review group that met on a monthly basis. This group comprised of the registered provider, centre manager, child care leaders and psychotherapist. Inspectors reviewed a sample of these minutes and found them to provide learning and analysis on incidents that had previously occurred. There was evidence of trends being identified and training being provided in relation to trends if required for example self-harm training.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 3.3**
Practices did not meet the required standard	**Standard 3.1** **Standard 3.2**

Actions required

- The registered provider must ensure all policies are reviewed to ensure that they comply with the requirements of the National Standards for Children's Residential Centres (HIQA) 2018.
- The registered provider and the centre manager must ensure staff members are aware of and familiar with both the organisation's policies and procedures for safeguarding and child protection and also the Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The centre manager must implement a child protection register to allow for tracking of concerns.
- The registered provider must ensure the organisation's recruitment policies are followed and appropriate safeguarding measures are in place. The registered provider must ensure current vetting processes are reviewed.
- The registered provider must ensure there is an auditing mechanism implemented that allows for clear oversight and governance of child protection and safeguarding.

- The registered provider must ensure the current pre-admission risk assessment tool is reviewed to account for preventative measures and impact of behaviours on other young people.
- The registered provider must ensure that a protected disclosures policy is developed and implemented. The centre manager must ensure that staff members are aware of and familiar with this policy.
- The registered provider must review the current behaviour management policy in line with the information being provided to management and staff members particularly around the use of restraint and ensure the two correlate. The individual crisis management plans must also be reviewed in line with this to ensure staff members are aware of the current approaches to behaviour management that are in place. The registered provider must review the current approaches to behaviour management to ensure any approaches and interventions used are assisting young people to manage and alter their behaviours.
- The centre manager must ensure that all staff members are aware of how to recognise and manage bullying behaviours between residents within the centre.
- The registered provider must ensure an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.
- The registered provider must ensure there are mechanisms in place for parents and social workers to provide feedback and identify areas for improvement.
- The centre manager must ensure any restrictive practice is risk assessed and regularly reviewed together with evidence of key working around same in an attempt to minimise behaviours.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The centre had a full suite of policies in place however these had not been reviewed since September 2018 and must now be reviewed to ensure that they comply with the requirements of the National Standards for Children's Residential Centres 2018, (HIQA). The registered provider informed inspectors they were currently working

with an outside agency to have new policies and procedures developed however could not provide a timeframe on completion of this project. The registered provider must ensure all policies are reviewed in line with standards in an appropriate timeframe. From a review of team meeting minutes, management meeting minutes and supervisions inspectors could not find evidence of regular policy discussion or review and the registered provider and centre manager must ensure this becomes part of daily practice within the centre.

Through interview with the centre manager and staff members, all demonstrated a limited understanding of legislation, regulations, policies and standards for the care and welfare of children. This needs to be refreshed with the care team as a matter of priority. The registered provider must ensure there are systems in place to alert them to any gaps in compliance with regulations and standards.

Standard 5.2

The centre, at the time of inspection, had a management structure in place that consisted of an acting centre manager supported by three child care leaders, all of whom had been appointed in the last six months. In addition to this there was the company director who was present in the service on a daily basis. It was evident through interview there was a lack of clarity around roles and responsibilities and the inexperience of the management team was evident through daily leadership. The registered provider must ensure that there are clearly defined roles and responsibilities for all members of management together with a clear support and supervision structure around each member of management. Arrangements were in place for when the centre manager took leave however this consisted of the registered provider stepping down into the manager's role.

The centre manager confirmed that at times some of their duties were delegated to social care leaders and staff members however this was mainly done verbally or through the staff communication book. There was no written record kept of when or to whom specific duties were delegated or the outcome of key decisions made following this delegation. The centre manager must implement a delegation record that highlights to whom such duties have been delegated, when this occurred and the key decisions and outcomes.

The registered provider confirmed there were appropriate service level agreements in place and that a bi annual report was provided to their funding body.

The centre had a risk assessment policy in place however there was no overarching risk management framework for the identification, assessment and management of risk. The organisation did not have a centre risk register or organisational risk register in place to account for risks specific to the overall operation of the service. The registered provider must develop a framework to identify asses and manage centre and organisational risks. The centre had provisions for out of hours support to staff through an on call service operated by management within the organisation.

Standard 5.3

The centre had a statement of purpose which briefly described the model of care together with the aims and objectives of the centre, the range of services available and the arrangements for the wellbeing and safety of children within the centre. The statement of purpose did not outline information relating to the management and staff employed in the centre and this should be reviewed to reflect same.

Inspectors found through interview that the statement of purpose of the centre was not understood by staff members or the centre manager. Inspectors did find that it was detailed in young people's booklets and parent's booklets. The statement of purpose also briefly outlined the centre's model of care however, those interviewed through the inspection process could not communicate the model of care, its theoretical basis or how it is applied in practise. It was noted to focus on a relationship-based model of care however there was no clear evidence of it being embedded in theory or any further elaboration as to how this relationship based model looked or would be achieved. Some practices and aspects of service delivery were not congruent with a relationship based model of care. The registered provider notified inspectors that the model of care will be reviewed in early 2020. The registered provider must ensure that adequate training is provided in relation to this.

Standard 5.4

The centre had a complaints policy however inspectors found that this was not implemented by staff members. There was no evidence of complaints being recorded despite evidence of same being expressed by young people through incidents and daily records. There appeared to be confusion around what constituted a complaint and the centre manager must adopt an approach that all expressions of dissatisfaction should be recorded and responded to. The registered provider must ensure the current complaints policy is congruent with Tusla 'Tell Us' and that it is implemented within the centre and understood by staff members. There was no

evidence of the registered provider ensuring complaints were monitored and analysed and a mechanism for same must be implemented.

The current auditing structure for the centre was of a two-fold nature. The centre was utilising a checklist provided by a previous monitor to the organisation which was no longer fit for purpose. This was being completed by an administrative assistant employed by the organisation. Inspectors found no oversight of this process from a social care trained professional and this was a tick box report as opposed to a qualitative analysis of practise. There was no evidence of the centre manager or registered provider completing assessments on the safety and quality of care being provided to young people in the centre. The registered provider had also outsourced an element of auditing to an external agency that had completed three audits in 2019. Inspectors reviewed these audits and found them to be of good quality particularly in relation to operational aspects of the centre. Inspectors found these auditors had identified similar deficits to that of the inspectors however these dated back as far as April 2019. While the audits were of a high standard, there was no evidence of findings being taken on board by the centre or evidence of any follow through being auctioned by the centre manager or registered provider. These audits also did not allow for a qualitative analysis of care through documents such as key working, placement planning and risk assessments. The registered provider must ensure that they develop and implement a governance tool to ensure that there is ongoing monitoring and assessment of the safety and quality of care being provided in the centre. This audit tool must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA). The registered provider must also ensure there is an annual review of compliance in relation to the centre's objectives completed. The registered provider and centre manager must ensure that audit recommendations are auctioned and followed through.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1**
Regulation not met	**Regulation 5**

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

Actions required

- The registered provider must ensure there are systems in place to alert them to any gaps in compliance with regulations and standards.
- The registered provider must ensure all policies are reviewed in line with standards in an appropriate timeframe and that they are understood in practise by staff members.
- The registered provider must ensure that there are clearly defined roles and responsibilities for all members of management together with a clear support and supervision structure around each member of management.
- The centre manager must implement a delegation record that highlights who such duties have been delegated to, dates of delegation of tasks and the key decisions and outcomes.
- The registered provider must develop a framework to identify, assess and manage centre and organisational risks.
- The registered provider must ensure that the statement of purpose is reviewed to include the management and staff employed in the centre.
- The registered provider must ensure the current model of care is reviewed and adequate training is provided to staff.
- The registered provider must ensure the current complaints policy is reviewed and that it is implemented within the centre and understood by staff members.
- The registered provider must implement a system for monitoring and analysing complaints.

- The registered provider must ensure that they develop and implement a governance tool to ensure that there is ongoing monitoring and assessment of the safety and quality of care being provided in the centre. This audit tool must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The registered provider and centre manager must ensure that audit recommendations are completed and followed through.
- The registered provider must ensure there are mechanisms in place for parents and social workers to provide feedback and identify areas for improvement.
- The registered provider must ensure there is an annual review of compliance in relation to the centre's objectives completed.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure all policies are reviewed in line with the National Standards for Children's Residential Centres, 2018 (HIQA).	Policies reviewed. New copy in place in centres since February 2020.	Review of document in monthly audit by manager and director. Policies to be discussed in staff meetings biweekly and additions incorporated when necessary.
	The registered provider and the centre manager must ensure staff members are aware of and familiar with both the organisation's policies and procedures for safeguarding and child protection and also Children First: National Guidance for the Protection and Welfare of Children, 2017.	Child protection training completed again on 10th January with external trainer. All staff being re-inducted this process will be completed by April 2020. Induction document improved and updated in February 2020 to include measures for accountability for staff engagement with such essential instruction. Follow up testing two weeks later has been included in the process and staffs continued employment is determined on results of such. All staff have completed etraining again.	Training to be refreshed every six months. Re-inductions to be completed with all staff after one years' service. All staff to be subject to unannounced checks/tests sporadically at the managers discretion. All will be recorded on personnel files and any deficit in knowledge addressed in supervision and with further training. All this information will be audited and direction given by the director after monthly audits/weekly managers reports.

	The centre manager must implement a child protection register to allow for tracking of concerns.	In place since January 2020. In place since February 2020. One person is now responsible for the process in its entirety and the responsibility lies with them to ensure all measures are accomplished before the file is put forward for induction.	To be overseen by the manager and subject to oversight by the director in monthly audits.
	The registered provider must ensure the organisation's recruitment policies are followed and appropriate safeguarding measures are in place.	As above this is now subject to triple verification.	Managers to be responsible for checking all information/verifications are finalised before a new individual starts induction. Director to also verify files are in order before commencement of employment. Check sheet is currently ready for new files to verify all individuals responsible have authenticated such.
	The registered provider must ensure current vetting processes are reviewed.	Tuslas Children first self assessment tool in use by managers since February 2020. Inductions and reinductions cover and record same. Weekly managers report/monthly audit reports concerns to the director. We are working on an integrative auditing and recording folder for all the above. To	Director to be responsible for the final file check before employment commences. This will be witnessed in the check sheet in each file. Manager and director to continue with cooperative exchange of relevant information in weekly reports/ monthly audits/ monthly meetings.

		be completed by May 2020.	
	The registered provider must ensure there is an auditing mechanism implemented that allows for clear oversight and governance of child protection and safeguarding.	Current tool is one provided by Tusla. We will develop our own pre admission risk assessment method. Manager has been requested to complete same by April 2020.	Once the latest tool is in place it can also be audited monthly by the director and manager.
	The registered provider must ensure the current pre-admission risk assessment tool is reviewed to account for preventative measures and impact of behaviours on other young people.	This policy is in place and is an element of our new induction process which determines if it's understood and unambiguous. It has also been included in our new policies and procedures. We have a designated person and the details of such are displayed in the office for staff. The policy was discussed with the team in a staff meeting and recorded as such.	New template to be approved by the director for use and oversight of such will be part of the governance auditing arrangements now in place.
	The registered provider must ensure that a protected disclosures policy is developed and implemented. The centre manager must ensure that staff	Being undertaken currently. Behaviour management plans in use in all files since December 2019. Discussion at staff meeting January 2020 in relation to	The manager will be responsible for recording and then escalating any information pertaining to such to the director who will then take over the

	members are aware of and familiar with this policy.	restraint policy. All icmps are reflective of same. We are currently undertaking as a staff team in collaboration with a consultant a handbook for our model of care. When this is completed in June 2020, we are looking at training in Theraplay for everyone to overhaul and give more supportive and practical skills to our staff to add to our current behaviour management techniques.	process of engagement with the designated liaison/Tusla to resolve the issue in a collaborative manner.
	The registered provider must review the current behaviour management policy in line with the information being provided to management and staff members particularly around the use of restraint and ensure the two correlate. The individual crisis management plans must also be reviewed in line with this to ensure staff members are aware of the current approaches to behaviour management that are in place.	We have amended our behaviour modification charts to be more reflective of each young person and their needs. Our psychotherapist is tasked with giving direction to staff around approaches she considers therapeutically supportive. She furnishes monthly reports including case conceptualisations of each child and discussion is had at team/serg/management meetings around our ability to manage and support the children. Keyworkers are tasked with implementing programmes to aid the	All ICMPs to be reflective of our nonrestraint policy. Manager to be responsible for auditing of these documents. Director to be responsible for auditing the managers assessment. Director is overseeing and included in the process of developing our own model of care handbook and for implementing the changes needed to the current behaviour management techniques and policy. By June 2020 we will have a majority of same completed and will then consider the next step we take as a team to improve our

		children with managing their emotions – we use two methods, the direction of one set of sessions is dictated by the Psychotherapist and the other is from a Foroige handbook.	service.
	The registered provider must review the current approaches to behaviour management to ensure any approaches and interventions used are assisting young people to manage and alter their behaviours.	In June 2020 we are considering a new approach to managing behaviour which would be a complete functional change to the way we have always operated.	This is an ongoing piece of work overseen and instructed by the director. It is all subject to monthly auditing by the manager and director.
	The centre manager must ensure that all staff members are aware of how to manage bullying behaviours between residents within the centre.	(While assessing this issue we developed a new policy for staff bullying and harassment this is now included in our policies. We have also developed a new disciplinary system for staff.) The bullying policy was discussed in a team meeting January 2020 with all staff, recorded as such and is part of the new induction procedure and subject to testing of staff for	All polices to be individually discussed in each team meeting and recorded as such. Induction to really make staff accountable for their compulsory knowledge base and sanctions to be applied if professional competency is lacking – as part of the new disciplinary procedures. Manager responsible for including two policies in each team meeting and director

		competency as part of the process.	responsible for auditing these notes to reflect same.
	The registered provider must ensure an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.	Manager has been instructed to develop an auditing tool to encompass all the work we do collectively to manage and support change of behaviour. May 2020.	Director to approve template for use in units. To be subject to monthly auditing by manager and director. Consultation with psychotherapist ongoing.
	The registered provider must ensure a restrictive practice policy is developed and implemented within the service.	We are currently undertaking work in this area. We have developed a restrictive practice template for use with the monthly audits which will let us review, remove and implement practices when necessary.	Manager to be responsible for the completion of the template and monthly auditing. Director to be responsible for the removal, implementation of restrictive practices in consultation with the manager and team. Governance audit to oversee also.
	The centre manager must ensure any restrictive practice is risk assessed and regularly reviewed together with evidence of key working around same in an attempt to minimise behaviours.	The template for restrictive practice includes the need for a risk assessment and keywork.	Manager is responsible for making sure all areas outlined in template eg keywork is complete and a clear connection of all the work is easily accessible. Director is responsible for auditing the paperwork.

5	The registered provider must ensure there are systems in place to alert them to any gaps in compliance with regulations and standards.	External monitoring company to be asked to undertake such as part of their auditing duties. Director to then action any findings into policies and procedures and daily workings. Immediately.	Director is responsible for auditing the centre on a monthly basis and completing an end of year audit and action plan for the following period. director is responsible for implementing the finding of the external auditors.
	The registered provider must ensure all policies are reviewed in line with standards in an appropriate timeframe and that they are understood in practise by staff members.	This is completed and staff meetings are the forum for discussion of same. Induction is also a further safeguard for certain integral policies.	To be audited monthly/yearly by the manager and director. Policies can be added, amended in due course and record of staff introduction to such will be in team meeting records.
	The registered provider must ensure that there are clearly defined roles and responsibilities for all members of management together with a clear support and supervision structure around each member of management.	Manager has resent job descriptions to all staff and reiterate supervision arrangements to same. Immediately.	Supervision to be audited monthly by the director. External supervision is in place for the manager and the director undertakes supervision monthly also.

	The centre manager must implement a delegation record that highlights who such duties have been delegated to, dates of delegation of tasks and the key decisions and outcomes.	This is in place.	Paperwork in relation to same to be readily available in staff office for all. Manager to be available to discuss same. Delegation record is subject to auditing by the director.
	The registered provider must develop a framework to identify, assess and manage centre and organisational risks.	The director is in consultation with Social Care Training Ireland is developing a framework to record the oversight and auditing of the centre. This will be in place in June 2020. Auditing is currently being undertaken along with numerous recorded meetings.	The director is responsible for the development of this auditing framework. Once the integrative system is in place it will allow for the clear evidence-based demonstration that the centre has proper governance structures in place. There will be a paper trail to show evidence of the directors role in the service.
	The registered provider must ensure that the statement of purpose is reviewed to include the management and staff employed in the centre.	This is complete	Manager and director to review the statement of purpose and function yearly.
	The registered provider must ensure the current model of care is reviewed and adequate training is provided to	Work being undertaken currently to be competed by June 2020. Patrick	Handbook is being developed by the staff team. The induction of new staff includes

	staff.	Tomlinson consulting with Joanne Prendergast and director to devise a training manual for staff in relation to model. Staff meeting biweekly Thursdays at 10am to have an integrative approach to this entire process.	training in our model of care with JP. They will be subject to ongoing appraisal of their knowledge of such with periodic exams on same at the discretion of the manager. An deficits in knowledge will then be addressed by the director with supports and training.
	The registered provider must ensure the current complaints policy is reviewed and that it is implemented within the centre and understood by staff members.	Complaints policy discussed in staff meeting and record of such. Complaints policy has been updated to direct staff that currently all expressions of dissatisfaction are complaints. We no longer operate formal and informal process.	Director to audit the complaints log monthly and take responsibility to see the process through to fruition.
	The registered provider must implement a system for monitoring and analysing complaints.	Deputy manager is tasked with developing a tool to analyse and monitor complaints. To be completed by May 2020.	Director to authorise the use of template before use and oversee such with monthly auditing.
	The registered provider must ensure that they develop and implement a governance tool to ensure that there is	In process to be completed by June 2020.	In process to be completed by June 2020.

	ongoing monitoring and assessment of the safety and quality of care being provided in the centre. This audit tool must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA).		
	The registered provider and centre manager must ensure that audit recommendations are completed and followed through.	To be actioned immediately	Director to ensure external auditors recommendations are implemented.
	The registered provider must ensure there are mechanisms in place for parents and social workers to provide feedback and identify areas for improvement.	Template complete for the formal feedback from professionals and families	Manager to oversee and escalate any issues to the director for remedy.
	The registered provider must ensure there is an annual review of compliance in relation to the centre's objectives completed.	To be completed by the director at each end of year and objectives for the following months to be outlined for the managers and staff.	Directors responsibility to complete same yearly.