An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 036**

**Year: 2022**

# Inspection Report

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| **Year:** | **2022** |
| **Name of Organisation:** | **Compass Child and Family Services Ltd** |
| **Registered Capacity:** | **Three young people** |
| **Type of Inspection:** | **Announced Themed Inspection** |
| **Date of inspection:** | **8th, 9th & 10th February 2022** |
| **Registration Status:** | **Registered from the 13th June 2021 to the 13th June 2024** |
| **Inspection Team:** | **Sinead Tierney**<br>**Lorna Wogan** |
| **Date Report Issued:** | **13th June 2022** |

# Contents

# 1. Information about the inspection process

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

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

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

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

## National Standards Framework

## 1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in November 2013. At the time of this inspection the centre was in its fourth registration and was in year one of the cycle. The centre was registered without attached conditions from the 13th of June 2021 to the 13th of June 2024.

The centre was registered as a multi-occupancy service to accommodate up to three young people of both genders aged 13 to 17 years on admission. The centre provided medium to long term care placements. The centre's care approach was underpinned by the principles of social pedagogy with a focus on learning, teaching and providing consistency of care from key adults. A primary focus of the work with young people was informed and guided by the understanding of attachment patterns observed in young people. At the time of inspection, there were two young people living in the centre; one young person aged between 13 and 17 and one young person aged under thirteen years. The centre had been granted a derogation to the registration status for this young people as they were under thirteen years of age on admission which was outside of the centre's statement of purpose.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| 2: Effective Care and Support | 2.2 |
| 5: Leadership, Governance and Management | 5.2 |
| 6: Responsive Workforce | 6.1 |

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

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

## 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 10th of March 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 24th of March.

The findings of this report and assessment of the submitted CAPA deem the centre not to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. This centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: *Care Practices and Operational Policies* and Article 7: *Staffing*. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 036 with attached conditions from the 13th of June 2021 to the 13th of June 2024 pursuant to Part VIII, 1991 Child Care Act.

That condition being:

- There must be no further admissions of a young person to this centre until such time the centre has fully implemented the corrective and preventative action plan and is compliant with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III Article 5: Care Practices and Operational Policies and Article 7: Staffing so that appropriate suitable care practices and operational policies are in place and the number, qualifications, experience and availability of members of the staff of the centre are adequate having regard to the number of children residing in the centre and the nature of their needs.

# 3. Inspection Findings

**Regulation 5: Care Practices and Operational Policies**

**Theme 2: Effective Care and Support**

**Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.**

At the time of inspection, two young people were living in the centre. One young person was aged under 13 years and the initial child in care review had taken place within the first month of placement. An up-to-date care plan was on file. Inspectors spent time with this child and observed caring and nurturing interactions between them and staff members. The child's Guardian ad Litem and social worker were interviewed by the inspectors. They reported that the young person expressed their happiness in how their room was decorated and individualised for them on admission and they had witnessed caring and warm relationships developing with staff. The purpose of the child's placement was to allow for a number of needs assessment to be undertaken. The social worker and Guardian ad Litem felt the centre team were working well to settle the child within the centre prior to the assessments commencing.

The other resident had lived in the centre for a number of years. An up-to-date care plan was on file, and they had been provided with opportunities to input into their child in care reviews. Inspectors spoke with both parents of this young person and with the allocated social worker. Their parents reported that the young person had made very good progress during their time in the centre and were satisfied with the care being provided. The young person's current social worker was allocated in October 2021 and had visited on one occasion with a second visit planned. They reported that from their initial assessment, the young person was doing well however they felt that the admission of a new resident was having some impact. Inspectors met with this young person, and they spoke of having good relationships with staff members they trusted. They voiced how they felt the admission of a new resident had impacted on them in that staff members attention was diverted to this young person and they felt somewhat left out. They had made a complaint to this effect, and this had been dealt with in an open and reflective manner by the centre manager with the complaint being upheld and addressed.

Both young people had placement plans developed however these were not consistently maintained on their care records. On request the plans were provided to inspectors. The centre manager informed inspectors that the placement plan template was recently updated to ensure it captured all the required needs and supports for young people as well as outcomes achieved. On review of placements plans it was found that whilst the plans identified needs and goals for the young people there was a lack of evidence that this work was undertaken by staff members and overseen by centre management. Plans were not signed by any member of the team or management and team meeting minutes did not demonstrate that discussions took place in relation to placement planning. There were no centre records that demonstrated that plans were developed with input from the staff team.

A review of key working records and individual work reports evidenced serious deficits in key areas of practice and oversight of practice. For example, whilst placement plans were in place for one young person for each month from October 2021 to January 2022 there was little evidence that work was undertaken to meet the needs and goals identified. In November and December no individual work or keyworking was recorded nor a discussion of the impact of another young person's discharge on them. In January, no planned or opportunity led work related to the placement plan or the impact of the new resident were recorded. There was evidence of significant copy and paste on progress reports with no evidence of accountability for work not completed either within the plans, progress reports or team meetings.

One young person's absence management plan was considerably out of date with no evidence on file that it had been reviewed in 21 months. The missing from care report template on file contained outdated and incorrect information. There was an accompanying absence document dated June 2021 that was written by a social pedagogue with no evidence that it was approved with a social worker or centre management. The record contained information that was contradictory to the absence management plan and sensitive personal information that was irrelevant to the management of absences.

During interview, management acknowledged that the opportunities for young people to input into their plans in an age-appropriate manner required strengthening. Some work had commenced in this regard and one young person had input into their care approaches. Good relationships had been established with one young person's family however parents had not been provided with opportunities to input into the placement plans.

Parents informed inspectors they had not been notified of a change in the centre manager, the young person's complaint or a significant event that took place in December 2021.

During interview, this young person's social worker informed inspectors they had not attempted to speak or meet with the parents since allocated to the young person in October 2021. To ensure the best interests of the young person are promoted, inspectors recommend that the social worker, centre management, and parents work together to establish an effective communication structure.

Both young people required the support of specialist services to assess and respond to their needs. There was evidence of advocacy work to ensure that young people had access to these supports. One young person was due to commence an assessment with the organisation's consultant psychologist however no member of staff or management could provide an update to inspectors on why this assessment had not commenced. The consultant psychologist also chaired clinical support meetings with staff. The purpose of the clinical meetings as outlined by senior management was to discuss the therapeutic needs and appropriate responses for young people. However, feedback from staff as noted in clinical meeting minutes was that agendas for group supervision and clinical meetings were overly similar. A decision was then made at a senior managers meeting that the deputy manager who was the designated manager in attendance would no longer attend the clinical meetings on a trial basis as it was felt that staff were more open to sharing their views when management were not present. Inspectors informed the registered proprietor of their concerns about this decision. In order to promote the best interests of the young people and ensure the team maintained a cohesive approach to their therapeutic needs; the person with named overall responsibility and accountability for service delivery must be present at clinical meetings.

A Guardian ad Litem and both young people's social workers were interviewed by inspectors. They reported that they were notified in a timely manner regarding significant events and reports and placement plans were also sent to them. On review of significant event notification forms, no details were recorded of this communication with key partners and agencies. During interview with the deputy manager, inspectors were informed of a restrictive practice in place. The centre's policy on restrictive practice was not followed in this instance as the supervising social worker was not informed this restrictive practice was put in place.

On balance, following a review of young people's care records, centre records, policies and interviews, inspectors have found that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5.

| Compliance with regulations | |
|---|---|
| **Regulation met** | **None Identified** |
| **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 2.2** |

**Actions required**

- The registered provider must review the placement planning process in line with the centre's policy to ensure that the needs of young people are met on an on-going basis. This includes how plans are developed, individual work is assigned and monitored, and outcomes achieved and acknowledged.
- The head of services must ensure that young people, families, and the care team have appropriate opportunities to input into placement plans.
- The regional residential services manager as interim centre manager must outline their oversight of care practices to ensure that keyworking and individual work is proactive, aligned to placement plans and is undertaken as scheduled.
- The regional residential services manager as interim centre manager must arrange for absence managements plans currently in place to be reviewed and updated in conjunction with social workers. A procedure to ensure that plans remain relevant and up to date must be included in the relevant policy.
- The registered provider must ensure that forums in place to oversee care practices are inclusive of management and those with overall designated responsibility for service delivery.
- The regional residential services manager as interim centre manager must ensure that details of key partners and agencies notified of significant events is maintained.

**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.**

A governance structure was in place that defined both internal and external management roles and responsibilities. The centre manager reported to the regional residential service manager who in turn reported to the head of services. The registered provider was the chief executive officer who was accountable to a board of directors. A contracting arrangement was in place with the Child and Family Agency and meetings took place as required.

Up to the 31st of January 2022, the centre had a named person in charge (PIC) who was also the named PIC for another centre within the organisation. A decision was made to appoint the PIC full-time to the other centre and subsequently the regional residential service manager was named the person in charge on an interim basis whilst a full-time manager was recruited. The PIC was supported in their leadership responsibilities by a deputy manager and three lead pedagogues. Social workers reported that management were open to guidance on caring for the young people.

The findings of inspectors following the observation of practice, meeting with the young people and interviews with management and external partners was that arrangements were being made to create a child-centred and safe environment. Nevertheless, these arrangements were not robust enough to oversee the management of care practices and operational policies and procedures.

Inspectors found a number of contributory factors that impacted on the registered providers ability to fulfil their governance responsibilities. The first of these related to the organisations culture that managers were not primarily based within the centre. Interviewees stated this was connected to the centres model of care and that experience had shown that their presence interfered with the relationship building between staff and young people.

Managers informed inspectors that the deputy centre manager attended handovers daily and then on an ad-hoc basis visited the centre. There were no records maintained of the management visits to the centre therefore inspectors could not ascertain a full picture of their presence.

Following a review of centre records the inspectors found there were periods of time when young people's needs increased, behaviours became unsafe and staffing numbers were insufficient. Records stated staff were "at risk of traumatisation and withdrawing from a young person" with energy and morale described as low. Presented with the changing environment for both young people and staff, management did not adapt their oversight and leadership approach to be responsive and ensure safe and effective care.

The second contributory factor was that the previous person in charge had responsibility for managing two centres. In practice a significant amount of responsibility for the centre's day to day operation was delegated to a recently appointed deputy manager. Whilst discussions were reported to have taken place with senior management during 2021 that highlighted the need for a full-time manager in each centre, no actions were taken to mitigate this until January 2022.

Inspectors found that a culture of accountability for deficits highlighted through audits was not evident. A quality audit of administrative systems in the centre was completed in January 2022. This found that while systems were in place, many were sporadically recorded and needed greater consistency and oversight. A review of team meeting minutes highlighted that actions central to the welfare of young people were re-occurring with no comments as to why actions were not completed by staff members within the timeframes identified. Inspectors noted that a pattern was emerging whereby staff were given responsibility for tasks that would generally be those of management. The registered provider must ensure that staff members primary role of providing effective and safe care of young people is not distracted from by completing tasks that others are responsible for. In developing a culture of accountability, the registered provider must ensure that all staff and managers fully understand their level of responsibility and effective systems are in place to achieve those responsibilities.

There was a delegation record in place that listed broad areas of responsibility and tasks for the deputy manager and lead pedagogues and the date assigned. This record did not keep note of key decisions made in the absence of the centre manager and must be updated to allow for documenting of such key decisions.

Responsibility for conducting audits and regular monitoring of the centre's compliance with legislative requirements, the National Standards and relevant policies was shared between the regional residential services manager and the head of services. Inspectors were provided with two themed audits for 2021, namely theme 1 and 2 of the National Standards. Inspectors found that a culture lacking respect for the living environment of the young people was a finding from an audit in October 2021 by the head of services. On review of the premises, inspectors found that improvements had been made to the living environment however further work was required. This was addressed with management and the registered provider and continued efforts must be made to ensure the centre remains compliant with standard 2.3. Several other deficits were identified in the audit however the timelines for action were unnecessarily long. For example, young people being informed of their rights was named as an action however inspectors found that five months post audit, no work was undertaken to address the deficit identified.

The centre had a suite of policies and procedures in place dated January 2021. Based on interviews, centre records and a review of relevant policies, inspectors found that some were not adhered to or understood at all levels in the organisation. An allegation of harm by a young person in 2021 was communicated to the allocated social worker in a timely manner however the child protection and welfare notification was not submitted until 18 days after the alleged harm and following the completion of an internal investigation by the centre manager. The vetting policy was not updated to reflect practice and a child safeguarding statement was not displayed as required under Children's First, 2017. The child safeguarding policy required updating to ensure it was fully in line with the requirement of Children's First, 2017.

A policy led risk management framework was in place that consisted of individual risk assessments for young people, a centre risk register, and a significant event review group. Inspectors found that the centre had made recent efforts to strengthen the significant event review process and recent reviews were found to be focused on developing the practice of staff and ensuring young people were responded to appropriately.

Other elements of the framework require attention and improvements to ensure they are purposeful and understood by all. This includes ensuring all known risks are assessed during the pre-admission process including how risks may impact on other young people. For example, the centre had no front gate and a young child who was recently admitted had left the grounds on several occasions. Whilst plans had been made to fit a gate, this safety measure should have been identified pre-admission.

One child also exhibited behaviours that if witnessed by another young person may have a significant impact. Whilst these behaviours were known prior to admission, the impact of them was not identified or assessed. A control measure identified within the risk register named the practice of 'informed intent'. During interviews with staff and management, inspectors were provided with several different definitions of what this meant in practice. Similarly, when a risk was classified as being monitored or open, there was no common understanding of what this meant in terms of monitoring the risk.

Overall, it is the finding of inspectors that the leadership, governance, and management arrangements are not robust enough to sustain a child-centred, safe and effective service. Consequently, the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5.

| **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 registered provider must provide a management plan that outlines how both the internal and external management will ensure that the oversight of care practices and operational policies will be robust and responsive.
- The registered provider and the head of services must ensure that outstanding actions named in the quality assurance audit (October 2021) are completed in a timely manner.
- The registered provider and the head of services must ensure that the centre is regularly audited and monitored throughout 2022 in a planned manner to ensure compliance.
- The registered provider and the head of services must review all policies and procedures and update these to ensure they reflect practice and are in line with the legislative requirements.

- The head of services must plan for an interactive refresher for all staff and managers on the centres policies and procedures.
- The registered provider must ensure that the internal and external management team are upskilled in their understanding and application of the risk management framework.
- The centre manager must ensure that in the event a young person witnesses the behaviour of another young person that is significant, that it is recorded and reported appropriately.

**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.**

The planning and management of the workforce was supported by policies related to recruitment, retention, induction, supervision, and continuous professional development. Inspectors found that some policies and practices related to planning and team dynamics were discussed at management meetings. The centre had arrangements in place to promote staff retention including access to an employee assistance programme, group supervision and educational supports. A policy led on-call system that included procedures for on-call at evenings and weekends was in place.

Key people in the lives of young people including parents, social workers, and a Guardian ad Litem spoke highly of the staff team and were complimentary of how they cared for and had built relationships with the young people.

Inspectors found that during 2021, the centre did not have the minimum number of staff required. In January 2022, the centre recruited additional staff and at the time of inspection the centre was staffed by eight team members (three lead pedagogues and five social pedagogues). A team of five relief staff or support pedagogues was also in place. Based on the needs of both young people and one young person requiring a staffing ratio of 2:1, the centre had a daily roster pattern of two sleep over shifts and one day shift.

The centre was not able to meet the needs of the young people with the eight full time staff rostered and required the ongoing support of the relief team in order to provide appropriate supervision of the young people. The person in charge informed inspectors that the centre required 9.5 full-time staff to meet the needs of two young people and was recruiting for these additional posts.

A review of rosters and staffing information provided to inspector's evidenced that a consistent staffing team was not available to young people. In the previous 7 months (June 2021 to January 2022) 23 individual staff members were rostered to care for the young people. It was the inspectors finding that this was not conducive to the model of care promoted by the organisation which upholds consistency of care from key adults as central to children's development. Inspectors found that the staffing rosters did not record the start and finish time of shifts; handover records did not record all staff in attendance or who was changing shifts and daily logs did not provide accurate information of all staff who were working. This is a safeguarding issue, and templates must be updated. The roster must record accurate start and finish times; the handover form must record the full details of all staff present and their shift pattern and the daily logs name all staff working in the centre on that day and their shift. Whilst the centre had a policy on appraisals there was no evidence that appraisals were planned for or took place with staff members. This was confirmed in staff interviews and was a required action from a previous inspection.

On review of personnel files the team had a mix of staff with varying qualifications. Four staff held a social care qualification, and four staff were unqualified in social care or a related field. Development plans were in place for two of these unqualified team members. Inspectors found that staff were promoted to positions of authority in the centre, subsequent to the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020) that did not hold a suitable or related qualification for the position. The registered provider must ensure they are compliant with the staffing regulations and the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).

The centre had a policy on induction of new employees however inspectors found that the process was not integrated into the service in a planned and systematic way as stated in the policy. The induction of new staff was led by the lead pedagogue with no evidence of oversight by management. Records evidenced that induction was not a learning process over time and new employees were expected to read a large volume of information on their first day in the centre including health and safety

procedures, young people's care records, all policies and procedures, child protection policies, centre duties and other procedures.

There were no supervision records for new staff on file therefore no assessment on their understanding of this information was evident. One new employee had no mandatory training records on file. The registered provider must ensure that all mandatory training for new employees is completed immediately. No induction plans or records were on file for staff promoted to leadership roles within the centre and the registered provider must ensure that the induction policy incorporates such planning.

Sample training records demonstrated that the majority of staff had their mandatory training completed. Whilst a training schedule had not yet been developed for 2022, interviewees informed inspectors of upcoming training related to understanding the needs of both young people.

Whilst the centre demonstrated that some practices met the required standards, it is the finding of inspectors that due to the insufficient numbers of staff to meet the needs of the young people that the centre is not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7.

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

**Actions required**

- The registered provider must ensure that the centre has sufficient numbers of permanent staff members to meet the needs of the young people.
- The regional residential service manager as interim manager must ensure the staffing roster, handover record and daily logs accurately reflect working hours and staff present in the centre.

- The regional residential services manager as interim manager must create development plans in conjunction with all staff who are unqualified in social care of a relevant field.
- The registered provider must ensure they are compliant with the staffing regulations and the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).
- The head of services must review the induction process for new staff and those promoted to positions of authority to ensure it is integrated in a planned and systematic manner as outlined in the policy.
- The regional residential services manager must ensure that all mandatory training for new employees is completed immediately.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| **2** | The registered provider must review the placement planning process in line with the centre's policy to ensure that the needs of young people are met on an on-going basis. This includes how plans are developed, individual work is assigned and monitored, and outcomes achieved and acknowledged. | An enhanced placement planning process was implemented in February 2022 that is in line with policy and will ensure that the placement plan is informed by the Care Plan, is comprehensive in terms of the needs of the young person and will be shared and agreed with the social work department on a monthly basis. There will be clearly identified areas of responsibility in relation to actions within the placement plan and these will be reviewed on a monthly basis. There are now specific intervention goals and key working pieces identified in the placement plan with oversight from the Centre Manager. | Each young person's placement plan is updated on a monthly basis and reviewed and signed by the centre manager before being shared with the wider professional team. During the implementation phase all placement plans will be reviewed by the regional manager and the process will be monitored through external audits. The social work department and other relevant professionals will be provided with a monthly progress reports. Training on the new process was provided to all managers at the management meeting on March 23rd. Care planning will be monitored by the regional manager and head of services monthly to ensure the new process is embedded in practice. The head of services will report to the CEO as part of the monthly governance meeting on placement planning and its effectiveness. |

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| | The head of services must ensure that young people, families, and the care team have appropriate opportunities to input into placement plans. | The enhanced placement planning process includes regular keyworking sessions where young people participate in their placement plan. Families are invited to Child in Care Review Meetings as guided by the placing social worker. Their input and feedback is welcomed via this platform. Placement plans are aligned with the care plan for each young person and are sent to the care team on a monthly for input and review. | Placement plans and goals will be reviewed with the young people on a monthly basis. The young people will be supported and encouraged to actively participate in age-appropriate goal setting and plans to achieve these goals. This will be documented as individual work and the centre manager will review these records. These records are also subject to regular external auditing by the regional manager. The young people's parents/guardians will be provided with a monthly progress report as appropriate and as guided by the placing social work department. All external audits are sent to the head of services upon completion. |
| | The regional residential services manager as interim centre manager must outline their oversight of care practices to ensure that keyworking and individual work is proactive, aligned to placement plans and is undertaken as scheduled. | Management presence has been increased to provide oversight and an outline of this provided to the inspectorate. A schedule of key working sessions for the month is drafted following the completion of the placement plan with individuals identified for having responsibility for completion of these. | The centre manager reviews the placement plan and keyworker schedule to ensure focused key working takes place and will evidence this in their monthly quality assurance audit. The regional manager will review key working practices through the external audit process. |

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| | The regional residential services manager as interim centre manager must arrange for absence managements plans currently in place to be reviewed and updated in conjunction with social workers. A procedure to ensure that plans remain relevant and up to date must be included in the relevant policy. | The absence management plans for both young people were reviewed and updated immediately following inspection, in conjunction with placing social workers. | Absence management plans will be reviewed monthly by the centre manager as part of their governance and any changes upon review communicated to the placing social worker. This is subject to review by the regional manager through external auditing. |
| | The registered provider must ensure that forums in place to oversee care practices are inclusive of management and those with overall designated responsibility for service delivery. | The centre manager and deputy manager will attend all forums which oversee care practices, including the monthly clinical supervision. | Records are held of attendance at meetings which are subject to external auditing by the regional manager. |
| | The regional residential services manager as interim centre manager must ensure that details of key partners and agencies notified of significant events is maintained. | The procedure on notification of significant events was outlined at a team meeting on 01.03.22. Adults on duty will complete the initial notifications by phone, and email notifications are recorded by the manager notifying the significant event. | Records of significant events, including the notification process, is reviewed by the regional manager as part of external auditing. |

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| | | This is overseen by the centre manager as part of their review of significant events. | |
| **5** | The registered provider must provide a management plan that outlines how both the internal and external management will ensure that the oversight of care practices and operational policies will be robust and responsive. | An interim manager was appointed to the centre in January 2022. A recruitment process is ongoing to appoint a permanent centre manager. Centre management presence in the house has been significantly increased on daily basis to ensure adequate oversight of care practices and operational policies. This increase has been outlined to the inspectorate. The presence will be increased further should the needs of the young people require it and in a responsive way to ensure oversight is adequate at all times. | An annual auditing schedule has been developed and the regional manager will visit the centre at least monthly to review care practices and operational policies and ensure the centre is compliant and robust internal oversight is in place. The head of services will carry out responsive auditing of the centre as required. These findings will be discussed at the monthly governance meeting with the CEO and head of services |
| | The registered provider and the head of services must ensure that outstanding actions named in the quality assurance audit (October 2021) are completed in a timely manner. | All outstanding actions on the quality assurance audit have now been completed, including the identified action on children's rights. | The internal and external auditing procedure has been reviewed. Once the audit has been completed the findings of the audit are shared with the manager within 2 weeks, inclusive of an action plan. The action plan is in line with the CAPA structure to ensure preventative actions are |

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| | | | implemented. Any findings requiring urgent attention will be addressed immediately. The regional manager will visit the house at least once per month and the internal audits will be reviewed on a monthly basis to ensure that these are being completed and that there is appropriate follow through on all identified actions. |
| | The registered provider and the head of services must ensure that the centre is regularly audited and monitored throughout 2022 in a planned manner to ensure compliance. | An auditing schedule for 2022 has been developed and will be implemented by the regional manager. | The auditing schedule is reviewed at the monthly governance meeting to ensure adherence to the auditing schedule and that the centre is compliant, with areas for action being addressed in a timely manner. |
| | The registered provider and the head of services must review all policies and procedures and update these to ensure they reflect practice and are in line with the legislative requirements. | The suite of policies and procedures is currently being updated to final completion and will be shared with the staff team upon completion. This will be completed in May 2022. | The organisation has employed a policy developer and researcher with extensive background in this area to oversee the development and implementation of the policy suite. |

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| | The head of services must plan for an interactive refresher for all staff and managers on the centres policies and procedures. | A training schedule for 2022 on policies and procedures has been agreed and will be implemented. The policy co-ordinator will provide training to the staff team on the completed policy document. | The regional manager has oversight of the policy and procedures process and responsibility for training being provided in this area. |
| | The registered provider must ensure that the internal and external management team are upskilled in their understanding and application of the risk management framework. | The risk management framework is under review by the CEO and this will be rolled to the management team to upskill the understanding and application of the risk management framework. This will be completed during quarter 2 of 2022. | The risk management framework will be subject to annual review and refresher training for the internal and external management team. |
| | The centre manager must ensure that in the event a young person witnesses the behaviour of another young person that is significant, that it is recorded and reported appropriately. | The requirement to record and report behaviour which is significant to another young person has been communicated to the team at a team meeting. | Records in the centre are subject to daily review by the managers to ensure that all information is recorded and reported appropriately. |
| **6** | The registered provider must ensure that the centre has | There is an ongoing recruitment process for additional support staff to ensure | There are a range of staff supports in place to promote staff retention and continuity of |

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| | sufficient numbers of permanent staff members to meet the needs of the young people. | adequate staffing numbers are maintained. The manager will provide the regional manager with a monthly assessment of staffing levels to ensure effective workforce planning. | care to ensure children experience stability. Workforce planning will be monitored by the CEO in the monthly governance meeting. |
| | The regional residential service manager as interim manager must ensure the staffing roster, handover record and daily logs accurately reflect working hours and staff present in the centre. | The centre rota, handover record, and daily logs have now updated to include start and finish times of scheduled hours and meetings. | The centre will keep records of planned and hours worked rotas which are subject to internal and external audit. Records of handover and daily logs are also subject to such auditing. |
| | The regional residential services manager as interim manager must create development plans in conjunction with all staff who are unqualified in social care of a relevant field. | A training agreement will be signed during April 2022 with the identified staff member. | Since February 2020 all recruitment has been in line with the memo and all further recruitment and promotion within the organisation will be in line with the regulations. |
| | The registered provider must ensure they are compliant with | This error has been amended and we are in the process of recruiting a social care | All recruitment practices are overseen and reviewed by the regional manager to ensure |

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| | the staffing regulations and the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020). | leader and this process will be compliant in relation to staffing qualifications. | recruitment and promotion within the organisation is in line with the memo on staffing numbers and qualifications (February 2020). |
| | The head of services must review the induction process for new staff and those promoted to positions of authority to ensure it is integrated in a planned and systematic manner as outlined in the policy. | The induction process is currently under review to ensure all responsibilities are understood by the employees, with greater management oversight. An induction programme for management and leadership positions will be developed and overseen by the regional manager. This will be completed by May 2022. | The regional manager will carry out a review of the induction and probation period and ensure a process is followed where induction and probation are kept under review and training needs/areas of development are identified. Induction policy to be updated to reflect clearer processes for management and social care leader positions. Q2, 2022. |
| | The regional residential services manager must ensure that all mandatory training for new employees is completed immediately. | Effectively immediately, the centre manager will ensure that all mandatory training for new employees is completed, and records are on file prior to taking up post. | The regional manager oversees the recruitment process and is informed by the centre manager that all mandatory training is in place prior to a new employee taking up post. |