An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 040

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Gateway Children's Services**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Announced**
Date of inspection:	**14th, 15th and 16th November 2022**
Registration Status:	**Registered from the 13th January 2022 to the 13th January 2025**
Inspection Team:	**Lorna Wogan** **Janice Ryan**
Date Report Issued:	**13th March 2023**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 14th January 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 13th of January 2022 to the 13th January 2025.

The centre was registered to accommodate two children, of all genders, from age thirteen to seventeen years on admission. The centre provided medium term care placements. The model of care was built on a strengths-based approach. The approach to working with young people was informed by attachment theory and resilience theory. The staff team aimed to increase protective factors and promote resilience by providing a safe environment, access to positive role models, opportunities to learn and develop skills and to build a sense of attachment/belonging. The approach was trauma informed and staff received training to understand the impact of trauma on child development. There were two children living in the centre at the time of the inspection. The centre was granted a derogation to accommodate one of the children as they were under thirteen years of age on admission which was outside the centre's statement of purpose.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.1.1. and 3.1.4, 3.2
4: Health, Wellbeing and Development	4.3

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

how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 13th February 2022 and to the relevant social work departments on the 13th February 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 23rd February 2022. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 040 without attached conditions from the 13th January 2022 to the 13th January 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The premises was located near a small village and was thirty minutes from a main town. The house, while small, was comfortable, bright and homely and there was evidence that the décor, furnishings, fixtures and fittings in areas of the house were upgraded during the year. The premises had only one communal sitting room for the young people's use however on review of the young people's care plans and their age range the inspectors were satisfied that both young people were afforded sufficient space for privacy. The kitchen and sitting room provided space for communal living and in-house recreational activities and were well used in this regard. This was confirmed by the young people who told the inspectors they had no complaints about the house. There was evidence that the children were encouraged and facilitated to invite their friends to the centre. The allocated social workers confirmed they were facilitated by staff to meet the young people in private.

The young people had their own bedrooms and there were suitable bathroom facilities for each young person. The inspectors viewed the bedrooms and found that young people had personalised their rooms and had sufficient space for storage. The young people were able to secure personal items in their bedrooms if they wished. There was evidence of suitable and age-appropriate games, books and toys in the centre. Art projects, photos and personal items were displayed in the centre.

The centre was clean and well maintained by staff with robust cleaning schedules in place. The centre was adequately lit, heated and ventilated. Laundry facilities were suitable, and the young people were involved in weekly chores and were responsible for keeping their bedrooms clean and tidy. A good standard of hygiene was

maintained in relation to the storage and preparation of food and the disposal of domestic refuse. A staff member had completed HACCP training in 2022.

The outside space to the front of the house was used to play football, the space at the back of the house was utilised for gardening projects and for keeping the centre pets. The inspectors found that the driveway up to the house was in a poor state of repair and upgrading of the entrance driveway should be undertaken in the coming year.

Maintenance requirements were recorded in a logbook in the centre. The inspectors found that repairs were completed in a timely manner. The inspectors found that there were gaps in the maintenance recording systems from September 2021 until May 2022 however this issue was rectified at the time of the inspection.

The inspectors found there were adequate precautions taken against the risk of fire, including adequate means of escape, arrangements for detecting, containing and extinguishing fires, and the maintenance of firefighting equipment. All, but one staff member, had undertaken fire safety training and that person was due to participate in the next scheduled training in fire safety. The centre had a named fire safety representative. All fire safety documentation was maintained on file. The inspectors found that maintenance checks carried out on the fire alarm and emergency lighting systems in 2021 were not recorded on the dedicated service record book, however the centre manager subsequently provided evidence of these service checks to the inspectors. The centre manager and staff must ensure the service engineers sign the dedicated service logbook following each maintenance check. The fire evacuation plan was displayed in the centre and the fire assembly point was identified on the grounds. Firefighting equipment was serviced annually with the most recent inspection in June 2022. There were systems in place to ensure fire equipment was checked internally by staff. There was a fire risk assessment logbook, and a nightly fire checklist that was completed by staff. There was evidence that regular fire drills were undertaken with some drills undertaken in the hours of darkness. The inspectors found that the young people participated in fire drills and newly appointed staff were familiarised with the fire evacuation procedures. There was a schedule of training in place for the newly recruited staff to undertake fire safety, first aid and manual handling training.

The centre had a written health and safety policy. A health and safety statement was developed in line with the legislation and was updated in 2022. Roles, responsibilities, and emergency contacts were set out in the statement and there was evidence that staff had read the safety statement. The centre had an appointed health

and safety representative, and they completed health and safety overview reports every three months. The staff also completed a weekly risk/hazard assessment of the premises that noted any presenting risks and preventative measures in place. There were procedures in place for the safe storage and administration of medicines along with systems in place for stock control and disposal of medications.

The centre maintained an accident and injury logbook however the inspectors found this logbook only commenced recording of accidents and injuries from May 2022. An external audit in February 2022 identified that there was no accident/injury logbook in operation in the centre with a recommendation to establish an accident/injury logbook however this recommendation was not actioned by the centre manager in a timely manner. The inspectors found several registers that had not been maintained up to date prior to the appointment of an interim manager and new deputy manager. These deficits had been identified by the current management team and were being addressed and rectified at the time of the inspection with more robust systems in place for oversight of administrative procedures and the recording practices in the centre. The current managers interviewed were familiar with the procedure for reporting workplace accidents is in line with health and safety legislation.

There were two vehicles onsite to transport the young people. The centre vehicles were found to be roadworthy, regularly serviced, insured, taxed, and driven by staff who were legally licensed to drive the vehicles. Copies of valid driving licenses for staff were evidenced on the personnel files reviewed by the inspectors. The centre recorded all vehicle maintenance checks and repairs and there were systems in place to undertake cleaning and visual checks on the centre vehicles. House maintenance requirements, fire safety and oversight of cars were standing agenda items at team meetings. Inspectors saw evidence that the centre was adequately insured.

Compliance with regulations	
Regulations met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
Regulations not met	**None Identified**

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

Actions required

- The centre manager must ensure the entrance driveway to the centre is resurfaced and maintained in a good state of repair.
- The centre manager and staff must ensure the service engineers sign the dedicated service logbook following each maintenance check on the fire alarm and the emergency lighting system.
- The centre manager must ensure that there are robust systems in place to ensure that all registers and logbooks are maintained up to date.

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

The new management team identified significant deficits in reporting significant events and in the identification, management and reporting of child protection concerns in line with Children First National Standards for Children's Residential Centres (HIQA), 2018. This further informed the providers decision to conduct a full and extensive review of all the paperwork associated with the period one of the current residents resided in the centre with the young person who was discharged. The newly appointed regional director found that the administrative systems were

insufficient in terms of tracking and locating child protection notifications to ensure they were submitted through the Tusla portal in circumstances where child protection concerns were identified on the significant event form. The young person interviewed by the inspectors relayed an incident of concern that occurred during their time living with the previous resident and neither the current managers or the social worker was aware of the event and there was no record of the event as outlined by the child evident on the care on file. The inspector requested that the regional director and the social worker meet with the young person to ascertain further details of this event and review the daily logs and the centre's administrative records for any records on the incident. The regional director informed the inspectors that they have recently developed a new governance audit tool for centre managers, and this will strengthen accountability in relation to the centre manager's role and responsibilities.

The inspectors found that the current filing and administrative system in place in the centre was clear and robust in terms of evidencing and tracking the relevant documentation and outcomes of reported child protection concerns. However, the inspectors found one instance where a staff member was unsure if their concern met the threshold for a mandated report and they waited until the centre manager, who was the designated liaison person, returned from leave to discuss the concern. There should be no delays in submitting child protection concerns within the organisation as the on-call managers are designated liaison persons and are available to discuss and advise on the reporting procedures in line with Children First National Guidance for the Protection and Welfare of Children, 2017.

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

The inspectors found there were policies and procedures in place to guide staff in the management of behaviour. The behaviour management policy outlined the focus on responding to pain-based behaviour and staff interviewed were able to describe this and how it fitted with their model of care and the behaviour management model. Staff had access to up-to-date knowledge and skills. Attachment training and training in the centre's model was scheduled for newly appointed staff and the service's attachment specialist provided the team with monthly forums to discuss the young people's presentation. Staff interviewed stated that the workshops with the attachment specialist were beneficial to them in their work. They were provided with guidance and direction in relation to care approaches and responding to the children's presenting needs. A record of this guidance and direction was maintained in the centre to ensure all staff were familiar with agreed approaches and the

rationale behind the approaches. The team had regular access to the behaviour management trainer who provided additional refreshers for the staff team in the behaviour management model when high-risk behaviours escalated. The service had recently contracted a new psychologist to work with the young people as required and they had commenced introductory sessions with one of the residents in the centre as agreed through the care planning process.

However, the inspectors found that the approach to managing behaviours that challenged were not always effective to support safe care for one of the former residents. Over the course of this young person's placement their behaviour oftentimes escalated to an unmanageable risk and thus ultimately resulted in an unplanned discharge from the service earlier in the year. This young person presented with behaviours that impacted on their safety and wellbeing and the safety of staff and the other resident in placement. In July 2022 the registered provider commissioned an independent review of the centre operations, management and care practices. The registered provider informed the inspectors that the initial draft findings of this review were due to be forwarded to the provider by the end of November 2022. The register provider must ensure that the outcome of this independent review is forwarded to the inspectors and findings relevant to the individual young people's care is forwarded to the relevant social workers. The inspectors found evidence that the staff team had stabilised over the past number of months and there was evidence of leadership, oversight and governance of practice within the centre with the appointment of an interim centre manager and new deputy manager. An additional senior management post was developed within the service with the appointment of a regional director of services in August 2022.

Overall, the inspectors found the approach to promoting positive behaviour and supporting behaviours that challenged was reflected in key work and individual work undertaken with the young people. There was evidence of ample key work and individual work where the young people were supported to develop an understanding of their behaviour and evidence that staff helped them to develop plans to manage their feelings when overwhelmed. The young people interviewed were familiar with their named key workers. They told the inspectors that they had good relationships with their key workers, and they got to spend individual time with them. There was no evidence of any incidents of bullying within the current resident group and both young people confirmed this when they spoke with the inspectors.

There was evidence that staff did not rely on sanctions to manage behaviours that challenged. There was a focus on natural consequences and staff supported the

young people find alternative ways to manage their feelings and behaviour. The centre maintained a record of consequences, and this was reviewed by the inspectors and consequences were found to be reasonable and fair and where possible linked to the behaviour.

There were several documents to guide and direct staff in the management of behaviour for example the individual crisis management plans, absence management plans and individual risk assessments. These plans were reviewed regularly and updated as required. Risks in relation to behavioural presentation were identified and subject to structured risk assessments. The risk assessments reviewed by the inspectors indicated that the review timeframe was monthly however there was no evidence of when the review was undertaken or if any additional controls were required or if the identified risks had decreased or increased. The centre manager should ensure the date of review of the risk assessment is evidenced and any changes to the risk assessment is discussed at the team meeting and recorded.

The centre had an incident and significant event management policy. Both social workers informed the inspectors that they were currently satisfied that they received both verbal and written notification of all significant events in a prompt and timely manner. However, one social worker informed the inspectors that prior to the change in management within the centre they had not received written notifications of significant events in a timely manner. On one visit to the centre the social worker had to request that hard copies of the significant events were printed off for them on site as they had not received them electronically. The inspectors found that earlier in the year significant event notifications were not consistently notified to the relevant parties in line with the National Standards for Children's Residential Centres, 2018 (HIQA) or in compliance with the centre's own significant event management policy.

The inspectors sampled the most recent significant event notifications for the centre. The reports were well detailed and written to a good professional standard with evidence of the therapeutic approach. There was evidence of oversight of these reports by the interim centre manager. The inspectors reviewed a piece of individual work undertaken with one young person and while on further investigation by the centre manager it did not meet the threshold for a mandated report the inspectors were of the view it should have been reported as a significant event. The centre manager stated that the social worker was aware of the incident however they agreed it required a significant event notification report.

Records of the significant event review group (SERG) were reviewed by the inspectors. The behaviour management trainer had a key role in the review of restraint interventions and provided guidance and support for staff to implement the behaviour management intervention effectively. There was little evidence on the team meeting records of feedback to the team from the SERG at a time when the team were struggling to manage periods of extremely challenging and high-risk behaviours. There was little evidence on the team meeting records of assessing or reviewing interventions or reviewing the team's capacity to respond to the presenting behaviours or reflection of the impact of these challenges on the team members. The regional director in conjunction with the senior managers should review the SERG process to ensure it is an effective process from a learning perspective, to identify patterns and trends in relation to high-risk behaviour, to assess the capacity of the team to safely manage the presenting behaviours and consider additional supports/resources or training that may be required by the team. Additionally, the service had an internal auditor however despite the challenges faced by the team in managing the young people's behaviour there was no specific audit undertaken of the centre's approach to managing behaviours that challenge as required under standard 3.2.5 of the National Standards for Children's Residential Centres (HIQA) 2018.

The inspectors found sufficient referral information on file for the new resident to assist staff formulate plans to respond to their presenting needs. There was evidence in the individual work records that staff helped the young person residing in the centre to prepare for the new admission. The inspectors found that there was careful consideration of the current placement mix and the inspectors found that both young people were settled and making good progress at the time of the inspection. There was an evident warm and friendly relationship between the two residents.

The centre completed risk assessments in relation to practices that were identified as restrictive. The inspectors found that the practice of locking internal doors to the kitchen and sitting room at night-time was not identified on the risk assessment as a restrictive practice. Furthermore, staff interviewed stated that the children were well settled at night and there was no evidence that internal doors were required to be locked with the current resident group. The centre manager must review the practice of locking internal doors at night-time. The centre staff must evidence the requirement to implement a restrictive procedure and ensure the restrictive procedure is used for the shortest duration necessary. A register of restrictive procedures may assist the centre manager in this regard to monitor and review the restrictive procedures on an ongoing basis. The centre records should also indicate that the social worker and the child's family, where involved in their children's care,

have been notified of the restrictive procedure in place. The inspectors found that the practice of using the child lock feature on the centre vehicle was identified as a restrictive procedure when in fact it is a safety measure when travelling with children in the car and is therefore incorrectly classified as a restrictive procedure. The centre manager should ensure that practices are categorised accurately in terms of being restrictive.

Compliance with regulations	
Regulations not met	**Regulation 5** **Regulation 16**

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 3.1.1, 3.1.4, 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The register provider must ensure that the outcome of the independent review is forwarded to the inspectors and findings relevant to the individual young people's care is forwarded to the relevant social workers.
- The regional director and the social worker must meet with the relevant young person to ascertain further details in relation to an incident reported by the child to the inspectors and review the daily logs and the centre's administrative records for any further information on the incident.
- The centre manager must ensure that child protection and welfare concerns are appropriately identified, managed and reported in line with Children First National Guidance for the Protection and Welfare of Children (DCYA), 2017 and that staff and managers receive regular training in safeguarding children and in the prevention, detection and response to abuse.
- The centre manager must ensure that all significant events are notified promptly, in writing, to the relevant parties in line of the National Standards for Children's Residential Centres (HIQA) 2018 and in accordance with the centre's own policy on the notification of significant events.
- The regional director in conjunction with the senior managers should review the SERG process to ensure it is an effective process from a learning perspective, to identify patterns and trends in relation to high-risk behaviour, to assess the capacity of the team to safely manage the presenting behaviours

and consider additional supports/resources or training that may be required by the team.

- The regional director must ensure that regular auditing and monitoring of the centre's approach to managing behaviours that challenge is undertaken by personnel external to the centre in line with the requirements of standard 3.2.5 of the National Standards for Children's Residential Centres (HIQA) 2018.
- The centre manager must review the restrictive procedures in place in the centre and ensure they are appropriately categorized, reviewed regularly, used for the shortest duration necessary, evidenced as agreed with social workers and notified to family as appropriate.

Theme 4: Health, Wellbeing and Development

Standard 4.3 Each child is provided with educational and training opportunities to maximise their individual strengths and abilities.

The inspectors found that the centre placed a strong emphasis on meeting the educational needs of the young people and there was evidence that staff sourced suitable educational placements appropriate to their abilities and educational needs. The young people did not require any additional educational assessments at the time of the inspection.

There were good routines in centre to ensure the young people were supported with their education. The young people were provided with transport to and from their educational placements. There were good homework routines in place for the younger resident. There were established systems in place to ensure clear communication with the education providers was maintained. The social workers interviewed were satisfied that the children were well supported with their education. There was evidence the centre manager had completed the relevant paperwork to apply for additional classroom support for one of the young people. There was evidence that staff supported the other resident to attend and complete their education and had identified various vocational training courses as a pathway to future career options. There was evidence that educational needs were discussed and reviewed at care planning meetings and within the context of the individual placement plans. Additionally, the inspectors found that each child was provided with opportunities to maximise their individual strengths and abilities. The young people were offered lots of opportunities to engage in extracurricular activities based on their individual strengths, abilities and interests.

Staff maintained detailed records of all professional contacts with the educational providers. School progress reports and educational achievements were maintained on the individual care records. There was evidence of oversight of the young people's educational progress at both team meetings and senior management meetings.

The younger resident had a good school attendance record while the older resident struggled periodically with school attendance. There was evidence that staff completed individual work and key work with this young person to explore the reasons why they struggled to attend their educational placement. The young people interviewed were aware if they did not attend school there were restrictions on particularly activities during school hours and an expectation that they would engage in an activity that provided a learning/development opportunity.

Compliance with standards	
Practices met the required standard	**Standard 4.3**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions Required

- None

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The Person in Charge (PIC) must ensure the entrance driveway to the centre is resurfaced and maintained in a good state of repair.	The PIC has discussed this with the Regional Director & Group CFO. They are liaising with the landlord for the premises. The driveway will be surfaced and repaired by August 2023.	Repairs to the driveway will be completed as they occur. Senior Managers are doing monthly Governance Meetings and will have oversight on the upkeep of the centre including the driveway.
	The PIC and staff must ensure the service engineers sign the dedicated service logbook following each maintenance check on the fire alarm and the emergency lighting system.	Fire Safety register has commenced since February 2023. The PIC and fire safety officer will oversee the completion and implementation of the Fire Safety Register.	Senior Managers will have oversight of this during their monthly governance visit to the centre. All maintenance works are also recorded in the monthly governance & oversight document which is forwarded to the Regional Director and Quality Director each month.
	The PIC must ensure that there are robust systems in place to ensure that all registers and logbooks are maintained up to date.	Since May 2022 a new management team was put in place. They have ensured that correct systems have been implemented to ensure all registers and logbooks are maintained. Since February 2023 Team Leaders have been appointed and they hold responsibility to ensure these systems	There is now an effective management structure within the centre. This consists of the PIC, Deputy Manager (DM) and Team Leaders. There is effective oversight of all logs and the PIC signs all logbooks and registers every fortnight to ensure all information is up to date and accurate.

		are running effectively.	
3	The register provider must ensure that the outcome of the independent review is forwarded to the inspectors and findings relevant to the individual young people's care is forwarded to the relevant social workers.	The independent review has been completed and the Regional Director has discussed the outcomes with the relevant social worker.	An executive summary of the independent review will be sent out to the inspectors and social workers by 10/03/23.
	The Regional Director and the social worker must meet with the relevant young person to ascertain further details in relation to an incident reported by the child to the inspectors and review the daily logs and the centre's administrative records for any further information on the incident.	Logs were reviewed and a member of staff who was on shift during this incident was spoken to for further details. A significant event notification and Child Protection Welfare Report was submitted retrospectively on 06.12.2022. The regional director has spoken to the social worker.	The regional director to visit the centre to speak with the resident no later than 10/03/23. Where new information is provided by the resident regarding any historical claim; this information will be explored gently and where relevant will be reported immediately to the Social Work Department.
	The PIC must ensure that child protection and welfare concerns are appropriately identified, managed and reported in line with Children First National Guidance for the Protection and Welfare of Children (DCYA), 2017 and that staff and managers receive regular training in safeguarding	Child safeguarding policy was discussed during the team meeting on 23.02.2023. PIC will facilitate staff to attend in house child protection training in April 2023.	CPWRs will be submitted through the Tusla Portal and this is monitored through the Monthly Governance and oversight report and followed up with check and challenge. Child protection training will be completed in April 2023.

	children and in the prevention, detection and response to abuse.		
	The PIC must ensure that all significant events are notified promptly, in writing, to the relevant parties in line of the National Standards for Children's Residential Centres (HIQA) 2018 and in accordance with the centre's own policy on the notification of significant events.	During the team meeting on 23.02.23 all staff were made aware that all on-call managers are named as a Designated Liaison Person (DLP). Where Child protection concerns arise, and the PIC / DM are off, guidance must be sought through the on-call DLP.	Significant event notifications will be forwarded to the social worker promptly and this is monitored through the Monthly Governance and oversight report and followed up with check and challenge. Monthly audits are conducted by Quality Assurance co-ordinator. All SENs are also forwarded to the Regional Director.
	The Regional Director in conjunction with the Senior Managers should review the SERG process to ensure it is an effective process from a learning perspective, to identify patterns and trends in relation to high-risk behaviour, to assess the capacity of the team to safely manage the presenting behaviours and consider additional supports/resources or training that may be required by the team.	This SERG process has been further developed to include a more detailed analysis of staff interventions and the effectiveness of these, this commenced November 2022.	Minutes from Management Meetings demonstrate discussion regarding SEN's. There is now a clear analysis, reflection, learning and service improvement noted throughout all SERG meetings. These meetings will continue monthly.
	The Regional Director must ensure that	Daily updates are sent to the Regional	SENs will be forwarded to the Regional Director promptly and this is monitored

	regular auditing and monitoring of the centre's approach to managing behaviours that challenge is undertaken by personnel external to the centre in line with the requirements of standard 3.2.5 of the National Standards for Children's Residential Centres (HIQA) 2018.	Director before 10am every morning. The PIC also now sends the Regional Director SENS promptly. The PIC sends their Monthly Governance and Oversight Report at the beginning of every month. Quality Assurance Co Ordinator is completing monthly unannounced audits.	through the Monthly Governance and oversight report and followed up with check and challenge with a senior manager. Monthly audits are conducted by the Quality Assurance co-ordinator. Regular TCI refreshers take place to ensure that managing behaviours that challenge are in line with this behavioural model of care.
	The PIC must review the restrictive procedures in place in the centre and ensure they are appropriately categorized, reviewed regularly, used for the shortest duration necessary, evidenced as agreed with social workers and notified to family as appropriate.	The PIC will review all risk assessments including restrictive practises and ensure that they are appropriately categorised. The PIC will ensure that the relevant young person's social worker and family members are aware of all restrictive practices in place (where appropriate). This will commence in March 2023. Risk assessment training was provided to all managers and deputy managers in October 2022, there will be a second day of this training provided in 2023.	All risk assessments including restrictive practises are recorded in monthly Governance and Oversight report. These are checked and challenged by Senior Manager monthly. Restrictive Practice Training to be completed by 31.03.23.
4	N/A		