An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 090

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Cottage Home Child and Family Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**10th & 11th May 2022**
Registration Status:	**Registered from the 17th of October 2020 to the 17th of October 2023**
Inspection Team:	**Eileen Woods** **Lorraine Egan**
Date Report Issued:	**4th August 2022**

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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 August 2000. At the time of this inspection the centre was in its eighth registration and was in year two of the cycle. The centre was registered without an attached condition from the 17th October 2020 to the 17th October 2023.

The centre was registered as a multi-occupancy service. The centre aimed to provide medium to long term care for four young people of both genders from age thirteen to eighteen years of age. The model of care was a relationship-based approach with the provision of a safe, secure and supportive environment to encourage the holistic development of each young person. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.1
4: Health, Wellbeing and Development	4.2

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 20th June 2022 and to the relevant social work departments on the 20th of July 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 8th of July 2022 after a short extension period was requested and granted. The CAPA was reviewed and the regulatory non-compliance identified in the report was addressed through a robust range of proposed actions. The proposed CAPA has been deemed as satisfactory by the Alternative Care Inspection and Monitoring Service and the relevant regulation now deemed to be met.

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: 090 without attached conditions from the 17th of October 2020 to the 17th of October 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

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

The young people were provided with booklets and leaflets as part of a pack of information available when they moved into the centre. Inspectors saw that there was some information displayed on a small notice board related to the availability of the complaints process at the centre, the availability of the Tusla 'Tell Us' complaints system and about EPIC, the national children in care advocacy and advice service. A young person told inspectors that staff had helped them to adapt to residential care and told them about what to expect including how to talk about something they were not sure of or unhappy about. Inspectors spoke with the chairperson of the board of management who informed inspectors that their visiting committee were resuming centre visits in this post pandemic period to meet directly with young people and with staff. The director of services visited the centre regularly and met with young people.

The staff offered young people's meetings once a month. The content, frequency and structure for these required improvement to allow for more discussion and information sharing to be reflected. The young people meeting records reviewed showed that it was not an effective forum for resolving issues for young people. Meeting records contained evidence of what some young people experienced as unresolved or unsatisfactorily resolved complaints. A young person told inspectors that they remained unsure about the meaning of some of the complaints outcomes and also wasn't sure what could happen about that.

Inspectors found that a review of how young people's voice flows through the organisation will assist in identifying and closing the gaps, this pertains particularly during periods of crisis in the centre when complaint rates can rise. The more embedded the practices are, the safer, heard and more supported young people should feel. Inspectors found that the parents and young people's information packs and forms must be reviewed to ensure that they accurately reflect the organisation's procedures for complaints including locally resolved day to day complaints. A social worker detailed positive feedback from themselves and from family members

regarding a young person's placement that, despite some issues and areas requiring attention, it was a good placement for that young person with evidence of staff one to one work and engagement. A second social worker was also happy with the experience so far of the young person's placement as was the young person themselves in talking to inspectors. A parent inspectors spoke with was happy with the information they had been given, how the staff team welcomed them and kept them informed. The young people indicated that they had staff that they could talk to at the centre and who discussed and made plans with them and that they felt safe there overall.

The centre had an updated set of policies that were in line with the National Standards for Children's Residential Centres, 2018 (HIQA). The policy and procedure on complaints outlined the revised 2020 onwards complaints procedures. The policy committed to training staff but this had yet to take place. The policy made a number of commitments to focus on patterns of complaints and to the education, training, monitoring, evaluation and reporting of complaints. The policy required updating to include a reference to the Tusla 'Tell Us' policy also. The centre had utilised the procedure for referring complaints against staff outwards to the individual social work departments for investigation. This led to some delays and the social care manager had acted to prompt speedier actions and meetings to ensure complaints were closed and outcomes recorded. This also though resulted in the centre missing crucial steps for themselves in addressing some internal issues and picking up on trends that they could have taken action on whilst awaiting social work co-operation. The overall implementation of the complaints process within the centre was not fully in line with the policy as it did not capture patterns and centre outcomes.

The centre register contained eleven complaints for the preceding twelve months, the majority took place in quarter one 2022. The centre register was pending an update for two of those. There was a recurring theme of young people remaining dissatisfied after the complaints were deemed closed. Inspectors found that there had not been a strategic analysis of complaints relating to their type, frequency and outcomes inclusive of feedback from young people. There had been seven complaints against staff practices from three different young people in the first quarter of 2022 and a number across quarters three and four in 2021. These were investigated and addressed through investigation by the relevant social work departments but inspectors could not find consistent records of follow up on practice or approach following these, although there was some.

The complaints on file at the centre were written and recorded, some took place during incidents and were identified and extracted from the narrative recorded. The director of services read the significant events inclusive of complaints and was the person in charge when the complaints related to the social care manager. The full range of actions, responses and follow up were not always maintained together so it was difficult to track how and when young people were responded to with the full outcomes and follow up after making a complaint.

Complaints were discussed at team meetings and in supervision regarding process and support. There had been disruption due to the impacts of the pandemic to the provision of supervision schedules and the social care manager and director were working to address that. It was noted by inspectors and by staff that they had not had the up to date edition training in their model of behaviour management and nor had they had many opportunities for additional complementary training. Addressing these deficits would enhance the team approach in the way they respond to young people's dissatisfactions.

Robust review of the implementation of the policy, the forms that support it through to how improvements take place was required. At the time of the previous June 2021 inspection the centre committed to improving young peoples experience post complaint outcome. At that time the centre outlined a number of ways in which this would be achieved and most of those were now in place but not as yet optimally used. In particular there was a gap in records of going back to young people to see how they were dealing with the outcomes, and it was not established practice to have restorative meetings to repair relationships, some did occur but not as standard.

What the management did have in place was a system of reporting, through the significant event system all incidents including complaints, reporting these upwards to the director in a monthly governance report and complaints were an agenda item at team meetings. There was also a significant event review group that looked at selected incidents for deeper scrutiny which on occasion included complaints. The social care manager and staff evidenced a transparency and commitment to capturing complaints and must now ensure that gaps in the process are addressed and senior management must ensure that they track complaint trends along with the centre management effectively.

Compliance with regulations	
Regulation met	**Regulation 16** **Regulation 17**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 1.6**

Actions required

- The centre management and staff team must review the content, frequency and structure for the young people's meetings.
- The director and social care management must review how young people's voice flows through the organisation and to make it more robust.
- The director must ensure that an analysis of the complaint's trends, themes and outcomes takes place and that any actions or improvements identified in terms of staff and service development are incorporated into the service development plan.
- The director and centre management must ensure that the records of all complaints are on file through to outcome and that the registers are brought up to date.
- The centre management and staff must do a robust review of the implementation of the current policy, the forms that support it through to how improvements take place after complaints are finalised. The staff team must reflect on how they capture everyday dissatisfactions as well as all other types of complaints that they resolve to ensure ongoing learning.
- The director and centre management must ensure that there is a plan in place to complete training in the up to date edition in the management of challenging behaviour training, without delay, for all staff and management including relief staff. The training in the complaints policy must also take place.

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 centre had a child safeguarding policy which was reviewed and updated in 2021. The policy was developed in line with the Children First: National Guidance for the Protection and Welfare of Children, 2017. There was also a child safeguarding statement updated in the month of this inspection, May 2022. This has been sent to the child safeguarding statement compliance unit for review. Inspectors found that staff had an awareness of their role as mandated persons and the social care manager had attended training in and held the role of designated liaison person (DLP). The centre policy does not outline the timeframes for renewals of the Children First national eLearning module: Introduction to Children First and should consider setting a timeline for this. The staff training excel did not differentiate between Children First eLearn training and internal child safeguarding policy training. Staff and management interviewed were uncertain as to when they had updated their eLearning module. The social care manager must adapt the training excel to better reflect types of training and when refreshers would be due for completion.

There was a child protection reporting register and knowledge displayed by the team of the appropriate reporting procedures. The social care manager had oversight of the incidents and had promoted use of the child protection reporting system if they noted areas of concern. They also tracked areas arising for discussion and escalation to Tusla. Inspectors found that in the area of disclosures that the team needed to revise their knowledge of their guidance on same. During a review of the centre records inspectors found that the staff must revise the advice contained within the policy in how to support and record a disclosure, for example, so that questions asked of a child are for clarification purposes only in line with best practice guidelines in their policy.

Staff interviewed knew the procedures related to allegations against a staff member and the social care manager and the director stated that they acted in accordance with their policies and procedures to complete reports through the child protection reporting portal and do risk assessments to guide decisions regarding allegations made against any staff.

There was a policy on anti-bullying and awareness on the team of the need to be alert to and proactive in prevention and education for young people. An area of the centre's work that inspectors found difficult to track was how any impact between peers, where it occurred, was managed and reported. The team meeting minutes did not record discussion regarding same. The significant events review group generated some actions and the centre must ensure to record and inform all social workers and relevant family if significant peer to peer impact occurs. The social workers had been made aware of non-residents being covertly brought into the centre on two occasions, they were not aware of the presence of illegal substances in the centre on an occasion.

Inspectors could not find evidence of a cohesive and clear review following incidents of this nature with regard to safeguarding and if any improvements were needed. There had not been a review to see if staffing and supervision levels at the centre were sufficient and successful. This must be done to ensure learning for ongoing safeguarding practices. Inspectors found that under their current staffing allocation, they struggled to maintain the staff numbers on duty as would be required to meet the young people's needs including management of incidents when the centre was near or at capacity. This would be represented as three staff on a daily basis with a capacity to increase to four when in crisis. The director and the board of management have made regular requests to meet with the relevant Child and Family Agency service level agreement management to review staffing allocation.

Safeguarding of young people was supported through incident reporting and connection to family and to social workers. It was also supported through the individual crisis management plans, absence management plans, safety plans. There were professional's meetings, strategy meetings and statutory reviews held. Some of the young people had medical, clinical and therapeutic professionals involved with whom the centre were in close contact. Inspectors found that the team must focus on how they integrate feedback from assessments and professionals to further inform safeguarding practices at the centre.

Inspectors found that it was difficult to track how strategies and interventions were put in place to improve and increase safety. The individual crisis management plans did not contain a clear map to addressing individual areas of vulnerability, there were no behaviour management plans or similar in use as a mechanism. Therefore, the safe care practices and communication practices where they related to areas of proven vulnerability such as self-isolation, low mood and suicidal ideation were not clear. The interviews conducted during the inspection however highlighted that the

safety practices exceeded what was reflected on the written individual safety plans and the plans on file must be more robust to support the whole team approach. Staff outlined the key role of daily handovers regarding interventions and safe care and support. Inspectors recommend that detailing more structured outcomes and advice from the significant event group will also strengthen practices at the centre alongside more detailed co-ordination of crisis management plans and safety plans.

The social care manager and staff must review where and in what detail they plan and review safeguarding practices to reflect their co-ordinated work in support of young people. It was noted by social workers that the centre was a good placement overall with lots of strengths. The team's role must focus on being proactive, curious and safety aware where risk is present.

Staff were less clear on agreements for informing parents on allegations of abuse and the centres policy does carry a short guidance on how this would be managed and the staff should familiarise themselves again with this guidance. The centre manager and staff were an experienced group who displayed evidence of communication and connection with family and there was significant skill and experience on this team in this area of their work day to day.

There was a policy on protected disclosures in place that staff were aware of at interview. The director of services has arranged structured policy training days and these commence in June 2022 and roll onwards from there with other bookings until all staff have covered all policies.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

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

Actions required

- The social care manager must ensure that all staff have current certificates in Children First eLearning module and adapt the training excel to better reflect types of training and when refreshers would be due for completion.
- The centre management and staff team must revise together the disclosures procedure and the key role of the DLP in these procedures.
- The director, social care manager and staff must review where and in what detail they plan for and review safeguarding practices to reflect their co-ordinated work in support of young people.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The young people in placement had care plans that outlined their current or initial health care needs. One young person was due to have an updated statutory care plan meeting for their placement. The placement plans were developed to take account of their health needs and a social worker confirmed that a young person had been registered with a GP and brought for a medical assessment shortly after admission.

The records demonstrated that extensive dental work had been facilitated and planned for as were eye tests. There was evidence of referral onwards, in conjunction with the social work department, for updated specialist assessment, such as occupational therapy and educational psychological assessment. The files did not contain records of all immunisations and the team must ensure that they seek the immunisation records for the young people inclusive of HPV vaccine status. Both social workers were happy with how the health care and appointment needs were managed. A parent stated they had been updated on all aspects of the general health care of their child and had good communication and advice from the team that supported the relationship.

In the period since the last inspection there had been complex medical and mental health needs for the team to support young people with. In the area of the medical and psychiatric needs the social care manager and staff had attended multi-

disciplinary meetings and sought to inform the relevant parties of risks and changes that would impact physical as well as mental health.

There were also ongoing mental health needs that required consistent follow up on a team level. The team received some guidance back on aspects of this from another specialised team on a young person's behalf. The social care manager detailed that they were to have access to advice from the Child and Family Agency assessment consultation therapy service (ACTS) but that there had been delays in availing of this in a manner that might have benefited a previous young person's placement. It was also clear from records seen that the recommended access to national mental health services for young people aged sixteen plus had not been available and that some public waiting lists were long.

Inspectors acknowledge that as a smaller voluntary body the centre was reliant on access to national services and inspectors found scope to enhance the experienced team's abilities by completion of their core training. The management team must consider how they maximise opportunities for access to clinical or therapeutic professionals to guide their centre based work. The director, social care manager and the staff inspectors spoke with all stated their commitment to and plans for harnessing training and development to support the work of building emotional strength and resilience with young people. Inspectors found that a team based therapeutic approach required renewed focus with recognition of the cognitive abilities of young people and on the features of low mood.

Inspectors found that the centre's medical and medication records for the young people required some attention and co-ordination to be up to date. The management of administration of medication was difficult for inspectors to follow at times. The team have a medication management policy and have had training in administration of medication in 2020 so should refer to that policy when reviewing the files. The staff team have been trained in first aid or booked for same and had trained in the use of ligature cutters with procedures and equipment available for same.

There had been management of controlled medications required by the team and this was a key risk factor and responsibility that they held for a period of time. The social care manager and staff outlined that they had liaised with a pharmacy for blister packs for the medication in tablet form and there were also injectable medications to be completed. Young people over sixteen could exercise their right to take responsibility for aspects of this and the team kept records of refusals or missing regular tranches of essential medications where it occurred. The social care manager

and team informed the relevant social work departments, the relevant hospital consultants, other professionals and parents of these medication issues either as they occurred or at regular meetings. There was a specific medications risk assessment inclusive of controls that inspectors found was not reviewed when issues occurred. The risk management system was not utilised to create a specific support plan in response to the increased risks.

There was no visible external governance audit as yet of the medications refusals, the medications errors and the role of the risk assessment in the medication management system. The director must ensure that in line with best practice in medication management that there is a response to medication issues. The director was aware of all issues as they occurred and spoke regularly with the social care manager and the social work department involved.

Compliance with regulations	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre management and team must ensure that they seek the immunisation records for the young people inclusive of HPV vaccine status for young people in that age group who are not attending mainstream school.
- The key workers for the young people must review the medical and medications folders to ensure they are up to date and contain the relevant information.
- The director and social care manager must ensure that in the risk management and governance of medication issues that the social care manager gets formal responses to the incident and governance reports submitted. And that the auditing and risk register systems respond to and address such matters in order to identify any actions that may support increased safety.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre management and staff team must review the content, frequency and structure for the young people's meetings.	Joint team meeting took place on 31/5/22 which reviewed young people's meeting as well as the complaints procedure. A discussion took place about how to make the young people's meetings more effective and inclusive for young people. Met with young people on 08/06/22 and asked for their input on how we can improve young people's meetings. Met with young people again on 04/07/ 22 to discuss this further as only the two newest young people were present, we plan to meet all of the young people individually by the 17th of July 2022. Young people meeting agenda/ how they are recorded to be amended based on finding of consultation of young people. EPIC plan to meet with all of the young people and the staff team to look at enhancing young people's participation in	Biannual review of effectiveness of meetings and young people engagement to take place as part of managers meetings with the director of care. This will be reviewed as part of the manager's audit of complaints and as part of the young person's monthly file review.

	The director and social care management must review how young people's voice flows through the organisation and to make it more robust.	the centre. The changes to young people's meetings should help the young people engage more in the process this will contribute to their voice flowing through the organisation. Young people's feedback will be sought as part of their five-week file review. Young people will be asked for input in relation to questions to be used for new employees as part of the interview process. The importance of evidencing the young people's voice through our paperwork/ young people's files will be discussed in team meetings and in staff supervisions.	
	The director must ensure that an analysis of the complaint's trends, themes and outcomes takes place and that any actions or improvements identified in terms of staff and service development are incorporated into the service development plan.	Changes to complaints process and logs ensures that young people's feedback is sought and heard. A new directors auditing tool created to review complaints. This will include an analysis of complaint trends, themes, and outcomes which will be incorporated into the service improvement plan.	This will be reviewed as part of Manager's and Director's Audits.

	The director and centre management must ensure that the records of all complaints are on file through to outcome and that the registers are brought up to date.	An Investigation meeting form has been developed to record the necessary conversations that have taken place and the recording process has been clearly explained to the staff team. New amended audit tool has been developed to review complaints.	A review will take place in July 2022 to evaluate the services improvements in relation to complaints. We will review complaints on an ongoing basis as part of managers meetings and director audits. Improved audit tools to include recommended changes.
	The centre management and staff must do a robust review of the implementation of the current policy, the forms that support it through to how improvements take place after complaints are finalised. The staff team must reflect on how they capture everyday dissatisfactions as well as all other types of complaints that they resolve to ensure ongoing learning.	Defined terms of reference for dealing with complaints has been developed and given to social workers. Amended logs developed to include recommended changes. New directors auditing tool created to review complaints. Director has created an action plan to address any deficits in the complaints process. Staff training has been completed with full time staff and will be completed with relief staff in the coming weeks. New protocol document has been developed and forwarded to all of the placing social workers and a discussion will take place around the social worker involvement each time a complaint needs	This will be reviewed as part of the manager monthly audit and the Directors audit. We have created a separate complaints section in each young person's file so that complaints can be easily traced and reviewed. Complaints training will be part of the induction process. This will be reviewed as part of Managers meeting to ensure its effectiveness.

		to be investigated. Logs have been amended to include feedback from the young people regarding the complaints process. Manager and Director audits will review this on an ongoing basis. The importance of evidencing the young people's voice through our paperwork/ young people's files will be discussed in team meetings and in staff supervisions. Staff will address/log any everyday dissatisfactions in the young people's files and how they are managed for ongoing learning. We have reviewed the recording system as part of the staff training so that all staff are clear on the process of recording.	The Manager will link with the social workers around the process and review this as part of the ongoing audit system.
	The director and centre management must ensure that there is a plan in place to complete training in the up to date edition in the management of challenging behaviour training, without delay, for all staff and management	Staff have been provided with training on the complaint procedure. All fulltime staff have completed TCI refreshers. Two full time staff cannot be certified as they must complete a full TCI course (due to missing a number of refreshers) in the autumn	This will be reviewed on an ongoing basis by the Manager and the Director as part of the audit process. The centre manager will identify which staff do not have TCI from the outset of their employment and will then source a course for the identified staff.

	including relief staff. The training in the complaints policy must also take place.	when there is a course available.	
3	The social care manager must ensure that all staff have valid, current certificates in children first eLearning module and adapt the training electronic spreadsheets to better reflect types of training and when refreshers would be due for completion. The centre management and staff team must revise together the disclosures procedure and the key role of the DLP in these procedures. The director, social care manager and staff must review where and in what detail they plan for and review safeguarding practices to reflect their co-ordinated work in support of young people.	All staff who needed to complete the E learning have done so. Review and of training of electronic spreadsheets to take place in July 2022 This review will take place at the team meeting on 12/7/22. How to handle disclosures will be reviewed with the staff team as part of the team meeting on the 12th of July 2022. Safeguarding practices will be reviewed as part of team meetings. Behavioural support plans/ BMP's are being designed and will be implemented by the September 2022. All SEN's are now reviewed under the questions: Was the intervention successful? Did it reduce the risk? Feedback from assessment/ professionals	Children first E learning is part of the induction process, and it will be reviewed by the Deputy Manager who will oversee training records. E learning is part of the induction process, and this aspect will be explained to all staff. This will be reviewed as part of the Manager and Director audit and the five week file review for each young person.

		will be brought to team meeting and individual supervisions where appropriate.BMP, ICMP and Risk assessments will be updated accordingly. An overall review of our current systems is taking place. The behaviour support plans being developed will include strategies and interventions for areas of vulnerability outside of management of challenging behaviour.	
4	The centre management and team must ensure that they seek the immunisation records for the young people inclusive of HPV vaccine status for young people in that age group who are not attending mainstream school. The key workers for the young people must review the medical and medications folders to ensure they are up to date and contain the relevant information.	Process has begun to retrieve the immunisation records for all current young people. Arrangements have been made for one young person to receive vaccines that they have missed. Keyworkers will review all of the medication folders and ensure all relevant documentation is present. This will be completed by the end of July 2022.	Immunisation records will be requested when young people are referred to the centre. This is part of the admissions checklist. Review of medication folder will be included in the monthly medication audit.

	The director and social care manager must ensure that in the risk management and governance of medication issues that the social care manager gets formal responses to the incident and governance reports submitted. And that the auditing and risk register systems respond to and address such matters in order to identify any actions that may support increased safety.	A response will be given by the director in relation to the risk management and governance of medication issues. A medication error risk assessment to be added to risk register and reviewed as part of managers meetings. This will be completed by the 17-07-22.	Audits will be responded to and noted on the audit. Medication error Sen's will be responded through the current system.