An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 097

Year: 2019

Alternative Care Inspection and Monitoring Service
Tusla - Child and Family Agency
Units 4/5, Nexus Building, 2nd Floor
Blanchardstown Corporate Park
Ballycoolin
Dublin 15 - D15 CF9K
01 8976857

Registration and Inspection Report

Inspection Year:	**2019**
Name of Organisation:	**Positive Care Ltd**
Registered Capacity:	**Four young people**
Dates of Inspection:	**29th of April and 9th of May 2019**
Registration Status:	**Registered from 22nd December 2017 to 22nd December 2020**
Inspection Team:	**Eileen Woods** **Lorraine Egan**
Date Report Issued:	**9th September 2019**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in December 2008. At the time of this inspection the centre were in their fourth registration and were in year two of the cycle. The centre was registered without attached conditions from the 22nd of December 2017 to the 22nd of December 2020.

The centre's purpose and function was to accommodate up to a maximum of four young people of both genders from age thirteen to seventeen years on admission with complex needs and challenging behaviour. Their model of care was described as a framework encompassing a range of intervention tools for example the PACE and SELF tools, a highly skilled team, management and clinical team providing a structured and stable placement. The model of care was to be relationship based and included work on trauma, family and goal setting for young people. Functional analysis and targeted planning was to be utilised to understand and intervene in harmful issues impacting young peoples' quality of life.

The inspectors examined aspects of standards 2 'management and staffing', standard 5 'planning for children and young people', standard 6 'behaviour management' and all of standard 7 'child protection and safeguarding' of the National Standards For Children's Residential Centres, 2001. This inspection was unannounced and took place on the 29th of April and the 09th May 2019. There were two young people living at the centre at the time.

1.2 Methodology

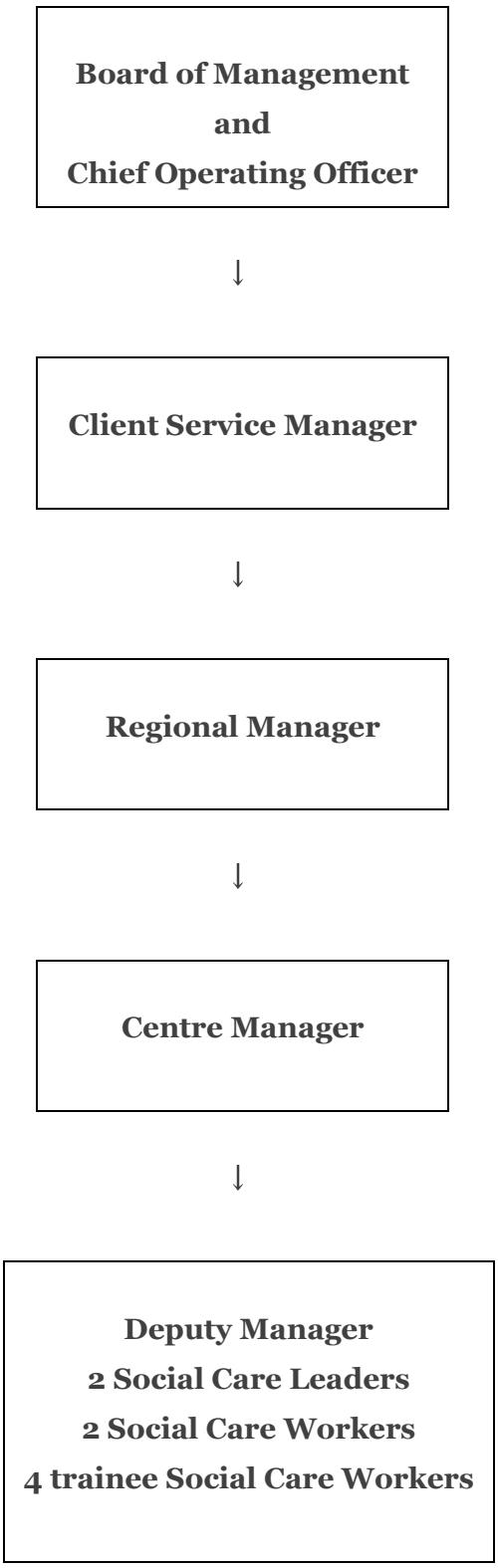
This report is based on a range of inspection techniques including:

- An examination of a questionnaire and related documentation completed by the manager.
- An examination of the questionnaires completed by:
    a) Three out of nine of the social care staff
    b) The two young people residing in the centre chose not to complete questionnaires
    c) The deputy manager
- An examination of the centre's files and recording process:
    - young people's care records
    - handover book
    - staff supervision records
    - training records
    - centre registers – admissions and discharges, complaints, significant events, sanctions and child protection.
    - management meeting minutes
    - internal quality assurance audits and action plans
    - centre policies and procedures
    - risk assessments
    - personnel files
- Interviews with relevant persons that were deemed by the inspection team to have a bona fide interest in the operation of the centre including but not exclusively
    a) The centre manager
    b) The company client services manager
    c) Two social care staff
    d) The lead inspector
    e) The two social workers with responsibility for the two young people residing in the centre
- Observations of care practice routines and the staff/young people's interactions.

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.

1.3 Organisational Structure



2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 22nd of July 2019. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 7th of August 2019 and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the 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: 097 without attached conditions from the 22nd of December 2017 to the 22nd of December 2020 pursuant to Part VIII, 1991 Child Care Act.

The period of registration being from 22nd of December 2017 to the 22nd of December 2020.

3. Analysis of Findings

3.2 Management and Staffing

Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

3.2.1 Practices that met the required standard in full

Notification of Significant Events

The centre had a system for the prompt notification of significant events. From interview with the lead inspector and the social workers for the young people it was noted that reports were sent in a timely manner and contained appropriate information. Inspectors found that the quality of the significant event notification register could be improved. The last written evidence of oversight found for this register was also twelve months prior.

3.2.2 Practices that met the required standard in some respect only

Management

A new manager commenced in post at this centre on the 1st of April 2019, this person was qualified and experienced for the role and had worked within this company for six years. The manager was supported by a deputy manager and two social care leaders on the team. The manager reported externally to the company client services manager on a weekly basis and in a weekly regional group of four managers through a video conference meeting. There was normally a regional manager in post but this was vacant at the time of this inspection, a recruitment process was underway. In addition the manager met the COO formally every second month, inspectors were told that the COO occasionally attended the weekly managers meeting also. Inspectors reviewed a sample of the weekly meeting records and found that a wide range of relevant headings were covered inclusive of policy, child protection, training and referrals from which brief action plans were then generated for each centre. Young people who scored above a specific threshold following a risk assessment were reviewed; this would in turn trigger input from the psychologist from the services' clinical team. Inspectors found that the full names and roles of the persons present at the meeting should be recorded and that the minutes should improve to reflect key

matters such as changes in centre management and discharges; these were not recorded in the minutes reviewed by inspectors.

The regional manager, when in post, undertook the day to day line management role for the centre and the Children First designated liaison person (DLP) role. Management utilised a regular auditing schedule to inform their oversight. The client services manager fulfilled these roles in the absence of an appointed person. Internal governance audits could be announced or unannounced and an action plan generated for the manager to respond to. The last recorded audit completed by a regional manager was in late December 2018 and early January 2019, this identified deficits that required immediate action: leadership in daily planning, key working oversight and gaps in supervision sessions were key areas named. An action plan addressing some of these was put in place for the previous manager to action from January of 2019. A number of changes in centre manager took place in the first quarter of 2019 with the result that when the new manager took up their position and the client services manager audited again in April 2019 they found that these areas still required attention. Inspectors recommend that the organisation review the focus and effectiveness of their external and internal governance reporting and recording systems to ascertain if the present system allows for early identification of areas of difficulty for managers. A system that allows for managers to be supported in transparently tracking work load and gain assistance at an early stage is recommended.

Inspectors found that there had been a period of disruption in the provision of management and governance to the centre due to changes in personnel and a vacant post from late 2018 to April of 2019 when the permanent manager was assigned. Qualified persons had been assigned to manage the centre in the interim but a number of changes took place in quick succession alongside two crisis discharges. The external management put arrangements in place to try to safeguard around some of these changes. Inspectors found evidence to support that the existing governance and oversight system did not function optimally to allow them to track and respond to trends arising. A social worker noted that the young person became disconnected from staff as they consistently predicted, accurately, that staff would leave. The centre team must now take account of the impact that the changes have had on the resident young people and plan in a dynamic manner to meet their individual needs.

Inspectors overall findings were that improvements were required in the quality and content of the weekly managers' meetings, in the flow of feedback and review of outcomes. The structure and content of team meetings, inclusive of the actions and

outcomes from supervision all required attention. The case management of key working had been lacking and stable assignment of key workers should be a priority. The new manager stated that since they had started in their post they had identified a number of key areas for attention in the planning for young people and development of the team.

Register

The register of young people did not contain parental details for the young people. The social worker details for another young person were absent. The last date of oversight on this register was July 2018. Another young person was entered as 'homeless' post discharge, the actual next location of this young person should have been sourced for this record. There was a system in place where duplicated records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

Staffing

The staff team comprised of ten persons inclusive of a manager and a deputy manager along with two social care leaders. At the time of this inspection out of a total of six social care workers, one was qualified, one due to qualify (May 2019) and the remaining four were trainees, in that they were not qualified to a minimum level 7 and above in social care or a relevant equivalent course. This represents a balance of unqualified to qualified social care workers and the line management must take account of this and make decisions on admissions accordingly. The manager must identify and track the training and development needs of the team closely in a manner that accounts clearly for their progression toward qualification. The manager had already identified the care framework as a core training that must be focused on. There has been a turnover of seven staff at the centre since the last inspection in 2017.

Four young people had been residing in the centre with two crisis discharges taking place since January of 2019 and the records did not reliably record staff day to day work with the young people in accordance with their plans so inspectors found some of the information difficult to track regarding interventions. The plans inspectors were provided with regarding the discharges reflected a high level of crisis management work having to take priority at times. It is important that the management now support the team in the implementation of the core framework for care, delivery on key working and review of progress with the young people. An emphasis on building relationships and supporting an atmosphere of safety and stability for the young people within the centre is also key.

Inspectors reviewed a sample of three personnel files and found that these contained up-to-date Garda vetting, contracts of employment, references and copies of qualifications, CVs and training certificates. The personnel files were in compliance with the relevant guidelines and any items noted outside this to improve consistency on the files were communicated to the management directly. There was evidence of an organisational induction being completed and the supervision files for two new staff evidenced a centre specific induction taking place, in one instance this was delayed. This included safe working procedures, role and responsibility and an introduction to the centre and its routines. Given the multiple changes at the centre and the qualification status of the team it is imperative that a suitable centre specific induction takes place and is recorded.

Supervision and support

The new manager and the deputy were trained in the provision of supervision, at the time of the inspection the manager had taken over supervision of the team bar two. The deputy had taken on some supervision since the 1st of April 2019. The manager and deputy had implemented a new supervision contract with staff, started supervision trackers and begun to deliver sessions in accordance with the policy of intervals of four to six weekly. Under the centres supervision policy newly employed trainee staff were to be supervised every two weeks for the first three months. Inspectors did not find consistent evidence of the two week provision of supervision on record at the centre.

Previous records of supervision for the preceding twelve months were provided to inspectors and these evidenced some gaps in dates and delivery, the content and focus was also uneven with regard to the development of the care approach at the centre.

The supervision template was lengthy and focused strongly on the placement plan development for the young people. Inspectors did not find that it robustly reflected the framework for care and recommend that this be focused on to a good standard within the supervisions and in the staff development plans. The client service manager, pending the appointment of a new regional manager, had commenced supervision for the new manager with a signed supervision contract and two sessions on file in the month since they had started in the post. The sessions reflected the updated job description, a centre specific induction and development needs identified for the centre and its team. There were actions named for implementation with a particular initial focus on audit findings and on the embedding in daily practice of the

care framework. The sessions also evidenced a suitable focus on review of the individual young people's needs and on the development of the team.

Inspectors reviewed the team meeting minutes for 2018 and 2019, the team meeting was stated to be monthly and at the time of the inspection three weekly with flexibility built in regarding scheduling where needed. The team meeting minutes overall did not represent a good account of discussions that may have taken place. Persons were listed by first name only and roles not identified. There were gaps in available team meeting minutes in 2018 with the last one on file being 26/11/2018 and the next on file being 21/2/2019. By the time of this first recorded team meeting of 2019, the previous manager was not in attendance and there was no record of the changes in manager. Review of previous minutes and actions were not recorded as routine and there was no evidence of discussions on the two discharges that took place. There was little or no evidence of external management in attendance at team meetings and aside from clinical input for a previous admission of a young person in 2018, inspectors could not identify direct clinical or therapeutic input through the team meeting framework either.

3.2.3 Practices that did not meet the required standard

None identified.

3.2.4 Regulation Based Requirements

The Child and Family Agency has met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV, Article 21, Register.***

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 5, Care Practices and Operational Policies
-Part III, Article 6, Paragraph 2, Change of Person in Charge
-Part III, Article 16, Notification of Significant Events.
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)

Required Action

- The COO and client services manager must lead a review of the effectiveness of their governance auditing, reporting and recording systems to ascertain if the present system safeguards good governance and best practice.
- The manager must review the internal governance systems in order to satisfy themselves that appropriate and suitable care practices and operational

policies are in place having regard to the number of children and the nature of their needs.

- The senior management team must significantly improve the records of, structure and content of weekly managers' meetings.
- The manager must ensure that the records of team meetings be significantly improved for accuracy including attendees, changes in personnel and placements, actions and review of outcomes.
- The COO and client services manager alongside the centre management must ensure that there are actions in place to have a balance of experienced and qualified social care staff in place.
- The manager must ensure that the supervision contracts and training and development programmes take account of the trainee status staff in accordance with the companies own policies and procedures.
- The manager and their management must ensure that the centre registers are reviewed and updated with the necessary information where identified.

3.5 Planning for Children and Young People

Standard

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

3.5.1 Practices that met the required standard in full

None identified.

3.5.2 Practices that met the required standard in some respect only

Suitable placements and admissions

The centre had a suitable policy and procedure to guide admissions and planning. Inspectors reviewed two pre admission files, the files for the two most recently discharged young people had been archived but inspectors reviewed some of the end of placement planning and discharge documents. The files contained a referral section, the contents of which included copies of previous care plans, social histories and any previous assessments. The young people had been given booklets about their

placement, information on their rights and the rules and expectations at the house along with a welcome pack, the young people had signed these documents. The files evidenced that a pre admission risk assessment had been completed and in the areas that reached the threshold to generate an individual risk assessment these were also on file. Inspectors found that whilst not fully aligned to the risk areas, they were substantially so and the new manager should review the whole pre admission file to advise future planning. A separate group impact risk assessment was also on each file.

The copy of the combined pre admission document contained preventative measures and strategies to be employed from the outset of the placement. The most recent admission plan stated that it should be reviewed monthly in line with the companies auditing requirements but inspectors could not track how or if this was done. The plan did not cross reference to child protection or to missing child in care protocols and should include these for future admissions.

Transition plans were devised and implemented, these were individualised and a pre admission planning meetings had been held during this time. This meeting addressed key areas like education and identifying therapeutic supports. The purpose of the placements and planning from pre admission onward should be brought together more cohesively. Also the balance of trainees on the social care worker team must be factored into decisions regarding admissions as well a full review of the two most recent crisis discharges to inform the best mix of young people aligned to the present skill base on the team.

Statutory care planning and review

The young people had a record of a recent child in care review and evidence of previous care plans and reviews having been held in accordance with the regulatory timeframes from 2018 and 2017. There were records on file of the various managers of the centre following up on gaining copies of care plans and child in care review minutes for the files. It was not always clear from the records if the centre had copies that they mistakenly archived or had never received them in the first place. The new manager must ensure that the most current/most recent care plans are not archived until suitable to do so.

The two young people did not have a copy of their current care plan on file. They did have some copies of subsequent child in care review minutes on file. The files of both young people made confident reference to a care plan suggesting one had been provided at some point. The social workers both stated that they thought a copy had

been sent previously but were supplying another copy to the centre at the time of the inspection.

Both young people had placement plans on file and these were evidenced as having been reviewed on a monthly basis throughout their placement. The social workers confirmed that these were forwarded to them. One social worker commented that they had recently found a positive change in these toward more creative methods of engagement with the young person. Another stated that they would welcome a renewed approach whilst acknowledging past efforts. Both named that relationship building and acknowledgment of the impact of change was fundamental to the process.

There were structured placement plans on the files with a goal tracking system but the format and content was dense and in small print; this made them difficult to utilise easily and quickly for a young person or staff wanting to make regular reference to them. The young person's own goals and their social workers were clearly outlined on the plans. Where family were involved, their wishes were also reflected and could be more prominent where family reunification was a goal.

Inspectors found that the most recent plans addressed areas matched to the care needs with persons responsible named and a review of goals achieved or not as part of the structure. Overall, across the previous placement plans the inspectors found a theme of good quality in places but with inconsistencies in priorities, decisions and follow through on other important areas for both young people. There was a mix of broadly stated areas of the plans alongside well stated and specific areas. The inspectors found that the plans presented best in the areas the team seemed most confident in. The plans included the young people's direct involvement, their comments and personal goals and if consistently followed through should be positive for the young people's future.

Inspectors found that the therapeutic aspects of the plans were the most difficult to accurately track and recommend that how the therapeutic process and specialist needs are followed be reconsidered within the format. The most recent placement plans did not address the aftermath of bullying and loss and it was difficult to track when and why some recommended specialist referrals and resources were or were not implemented. The two social workers clarified some of the information on these aspects outlining that many efforts had been made with one young person and for another that the social work team were happy with the pace of therapeutic intervention.

The key working records reviewed demonstrated that key work plans were created and goals identified for follow through and in April 2019 there was evidence of a refocused key work plan with detail, resources and how they were to be achieved. The areas identified were more structured and consistent with the young people's needs. For one young person there were six names listed as key workers since January 2019 with three listed as introducing themselves as the new key worker so the young people will need the necessary time and support to deal with all the recent changes. Both young people have named to different persons internally and externally that the changes in staff make it hard to trust and make relationships they can rely on.

Discharges

Two crisis discharges took place at this centre in the first four months of 2019. Inspectors reviewed placement at risk review forms, progress reports and discharge reports for the two young people.

The centre and company response mechanisms were triggered through a risk rating system that starts a clinical review usually in the form of a functional analysis to ascertain needs in a specific area. Inspectors found that comprehensive risk assessments were generated and Gardaí consulted where applicable.

The issues that pertained included aggression, use of weapons, criminal behaviour, drugs and significant mental health needs. On two occasions different combinations of young people had to be protected from each other and two peers in particular had to be protected from attack by the intervention of staff members. Actions such as separation of the group through respite and higher staffing levels did not assist in reducing the risks nor did it stabilise the group.

The centre and management records reviewed by inspectors did not reflect how ultimately the decisions were reached for the timing of these discharges. There was no recorded analysis or discussion of these in the regional meetings, the audits, the team meetings or the supervisions. What inspectors did find was child protection reporting regarding the impact and targeting of other residents, complaints from those residents and ongoing commentary by a young person to those staff they were familiar with about how unsafe they felt and still feel. There was no therapeutic response or post crisis debrief recorded specific to the aftermath for the young people or the staff.

Aftercare

One young person was engaged in preparation for leaving care and their aftercare plan was pending for their file. Due to difficulties with unfilled posts in aftercare in this young person's social work area a regional aftercare team will be stepping in to support the social worker and the young person in the planning. The social worker had convened a number of aftercare meetings with more scheduled. Inspectors were told that an aftercare plan will shortly be available for the file.

The young person's aftercare needs were well reflected on their recent placement plans. Inspectors and the social worker noted that significant focus is now needed for this plan to reduce this young person's risk of homelessness over eighteen.

3.5.3 Practices that did not meet the required standard

None identified

3.5.4 Regulation Based Requirements

The Child and Family Agency have met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995***

-Part IV, Article 23, Paragraphs 1 and 2, Care Plans

-Part IV, Article 23, paragraphs 3 and 4, Consultation Re: Care Plan

-Part V, Article 25 and 26, Care Plan Reviews

-Part IV, Article 24, Visitation by Authorised Persons

-Part IV, Article 22, Case Files.

Required Action

- The manager must ensure that the admission plans are reviewed monthly in line with the company's policy and auditing requirements.
- The manager must ensure that the purpose of the placements is reviewed and discussed with the social workers and the young people, and families where relevant; to ensure tailored planning continues to support the purpose.
- The operational management team must take account of the balance of qualified and experienced staff and learning from recent outcomes when making decisions regarding admissions in order to inform the best mix of young people aligned to the present skill base on the team.
- The manager must review and improve the presentation of the placement plan inclusive of consistency in the implementation of meaningful and individualised key working.

- The external management alongside the management of the centre must complete a full evidenced review of the two most recent discharges with feedback to the team and any actions for practice outlined.

3.6 Care of Young People

Standard

Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

3.6.1 Practices that met the required standard in full

None identified

3.6.2 Practices that met the required standard in some respect only

Managing behaviour

The centre had policies and practices in place to support a structured behaviour management approach linked to the framework for care - 'Managing behaviours that challenge' policy and procedure. Inspectors found that both files reviewed contained individualised crisis management plans, risk assessments and safety plans where applicable. The files had guideline documents tailored to each young person and these reflected the findings and diagnoses relevant to that young person. Some of these plans had been reviewed by the new manager and some were due for review. A functional assessment report by a clinical psychologist was on file and a support plan extracted from that to identify the degree of supports needed and naming what is already in place. Inspectors did not find that the recommendations from this were clearly visible on the placement plan or other support documents to a good standard. The provision of stable assigned key workers who have access to the resources and advice they need must be prioritised.

The staff team were trained in a recognised model for the de-escalation of behaviour and physical intervention. The young people had individualised crisis management plans, ICMPs, on file. Inspectors found that these were densely packed with content and inspectors also found that the use of language on one was not appropriate and

not in line with some of the known diagnoses and recent experiences for the young people within the centre. The purpose of the ICMP's was also not to the fore given the extent of the content. A significant amount of the content was relevant to a behaviour support plan rather than a crisis management plan. These must be reviewed and young people should be supported to input into their own plans where they wish to do so.

Inspectors found that whilst there was a strong underlying policy and document system underpinning behaviour management planning that it had not been fully congruent with the young people's experiences, diagnoses and impact from changes in managers and staff. One young person noted that it was very difficult to be challenged by new staff with whom they did not have a relationship and trust established and who may not fully know the rules as yet. Another noted that they could predict that staff would leave. Inspectors found that the new manager had started a process of review and that the client services manager was fully supporting of this. Some of the behaviour management plans on file displayed a caring approach. Where they were updated the plans had preventative measures and contingencies with manager commentary added. All the behaviour management documents need to be brought to the same standard and tracked with regard to their relationship to the model of care and team training.

The team utilised related consequences and sanctions, these were recorded on the files. The sanctions mainly involved loss of free time outside the centre and fines for damages. These records on files lacked dates and evidence of oversight and should be updated by the team.

3.6.3 Practices that did not meet the required standard

None identified

Required Action

- The management must ensure that the individual crisis management plans and the behaviour management plans are reviewed for content and tone to ensure they are up to date and fully geared to their intended purpose.

3.7 Safeguarding and Child Protection

Standard

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

3.7.1 Practices that met the required standard in full

None identified

3.7.2 Practices that met the required standard in some respect only

The centre had a 'Safeguarding and protection of young people from abuse policy statement: definitions, roles and responsibilities'. There was a policy and procedure process flow chart available in the policy document. There were a number of commitments in this document that were not active at the time of this inspection for example, signs of safety was not referenced, staff training in specific named tools was not fully completed, the regional manager role was vacant at that time. There was a commitment to child protection audits and reviews and these were evident in previous audits carried out. The policy and procedure document was regularly updated, extensive and informative.

There had been incidents of bullying and cyber bullying for young people and actions were required to follow up on these fully, regarding the impact post event on the young people and if all contact and actions had been completed regarding the cyber bullying. The key working records did not contain evidence of sessions regarding social media safety.

Young people had been provided with information regarding their rights and the details of persons outside the centre that they could contact for advice and support should they wish to do so. The young people were also given the details of EPIC, empowering people in care and their representatives have been invited to the centre. Both social workers have met with their young person regularly and had regular contact with them and meetings regarding their care.

Child Protection

Standard

There are systems in place to protect young people from abuse. Staff are aware of and implement practices which are designed to protect young people in care.

The staff team in place at the time of the inspection were recorded as having completed the required e-learning in Children First. A number of staff had completed additional complementary training in child protection and inspectors recommend that policy and procedure knowledge in safeguarding and child protection be maintained as a live aspect of the team meetings and in supervision. The centre has a child safeguarding statement, CSS, in place that had been updated on the 12th April 2019 to include the new manager's name and the version number is tracked as part of document management systems within the company. Inspectors recommend that this be forwarded to the Tusla child safeguarding statement compliance unit, CSSCU, for review as the designated liaison person is not named on the document and a number of individualised entries regarding behaviours mean it is specific to certain young people and this is not required for a child safeguarding statement. Inspectors also found that not all staff were trained in the named tools and that the clinical input referenced on it was not evident in the manner described. The manager and the senior management must review the practices in line with the policy and with the CSS.

A child protection and welfare reporting form register was maintained at the centre and there was evidence of the previous regional manager overseeing this and tracking the events through to outcomes for the record. The individual child protection records were maintained on the young people's files and included matters related to patterns of bullying. Additional safeguarding related information was notified to social workers directly and acted upon at the centre. Inspectors found that the register must be reviewed for its format to include the portal reporting numbers and that the manager should review the individual child protection records on the files to ensure that the full outcomes and follow up completed with the young people are reflected on file.

3.7.3 Practices that did not meet the required standard

None identified

Required Action

- The management must review the centres practices in line with child protection and safeguarding policies. The child safeguarding statement should be forwarded to the Tusla child safeguarding compliance unit for review and feedback.
- The management must review the child protection reporting register to ensure it is accurately structured.
- The management must ensure that each young person's file has the full content related to actions and outcomes completed, following a child protection notification made.

4. Action Plan

Standard	Issue Requiring Action	Response with Time Scales	Corrective and Preventive Strategies To Ensure Issues Do Not Arise Again
3.2	The COO and client services manager must lead a review of the effectiveness of their governance auditing, reporting and recording systems.	A review of the effectiveness of governance auditing reporting and recording systems conducted by Senior Management in relation to this centre concluded that whilst deficits were identified and action plans put in place to rectify issues between December 2018 and January 2019 there were shortcomings in relation to the follow through and ensuring that actions were completed. In response going forward Centre Management will receive immediate direct support from Senior Management to implement action plans identified in Audits.	Triple lock measures are in place to ensure that follow through on identified actions emanating from internal audits are completed. The Regional Manager on completion of Audits will support Centre Management in ensuring all actions identified in audits are actioned immediately. The Client Service Managers role will be to ensure that trends or identified issues emanating from these audits are identified and responded to with the focus being to provide additional supports and resources to assist Centre Management. The third level of governance and oversight has been the appointment of a Quality Assurance Specialist to the Senior Management Team. The Quality Assurance Specialist will be tasked with ensuring that all practises and procedures in place to support the young people in their

			placements at the centre will be in compliant with and in accordance with Policies and Procedures.
	The manager must review the internal governance systems in order to satisfy themselves that appropriate and suitable care practices and operational policies are in place having regard to the number of children and the nature of their needs.	This review has occurred and an emphasis has been placed on training and development and up skilling of all staff members and of implementing training and development plans with built in review dates for appraisal and additional support if required; the purpose of these measures is ultimately to ensure that the needs of the young people in the centre will be met.	Training and development plans, regular supervision and clinical guidance and support and regular team meetings are the measures that will be applied with consistency across the staff team to ensure that there are no deficits in relation to ensuring that suitable care practices and policies are in place to ensure the needs of the young people are being met. Centre Management will conduct Monthly Compliance checks in relation to internal governance with these measures also being subject to review during monthly Regional manager Audits.
	The senior management team must significantly improve the records of, structure and content of weekly managers' meetings.	A review has occurred and follow up has occurred in relation to how these meetings were being minuted. Improvements have been made to the template structure and content of these meetings with this change now in place.	New template to Unit managers meeting is in place

	The manager must ensure that the records of team meetings be significantly improved for accuracy including attendees, changes in personnel and placements, actions and review of outcomes.	The Centre Management has made changes to how the team meetings are being recorded. Since inspection a new template has been introduced this ensures that all aspects of care provision is referenced during team meetings. The first item on the agenda of these team meetings is a review of actions emanating from the previous meeting with a review of outcomes to the fore.	A new format and template has been introduced for team meetings at the Centre.
	The COO and client services manager alongside the centre management must ensure that there are actions in place to have a balance of experienced and qualified social care staff in place.	Of the 6 Social Care Workers identified at the time of inspection 1 has since qualified. Two of the unqualified staff are working towards a degree in Social Care and are subject to more regular supervision and support. The remaining 2 Social Care Workers are experienced having worked as Social Care Workers for 2 years and 9 months and 3 years and 5 months respectively. They do not have a recognised qualification but will be supported to work towards having a recognised qualification. Rostering arrangements will ensure that there is a balance of experienced and qualified staff	All new appointments to the Centre staff team will only be fully qualified staff with a recognised qualification.

		on each shift.	
	The manager must ensure that the supervision contracts and training and development programmes take account of the trainee status staff in accordance with the companies own policies and procedures.	Trainee staff will receive supervision of at least 1 hour duration every 2-3 weeks. New staff will receive supervision commensurate with their training and development needs. The supervision will include feedback on performance with the focus being on continuous professional development and performance appraisal. Supports will include developing their knowledge of the Care Framework and developing their understanding and implementation of theory to practice when working with young people.	Monitoring and evaluation of the standard of supervision, training and development plans and performance appraisal of all staff will form an integral part of the Regional Managers monthly audits.
	The manager and their management must ensure that the centre registers are reviewed and updated with the necessary information where identified.	Centre registers have been reviewed and updated with all necessary information included.	The Regional Manager audit will ensure that all centre registers contain all required information and are updated when required.
3.5	The manager must ensure that the admission plans are reviewed monthly in line with the company's policy and auditing requirements.	The Centre Management Compliance check is in place which includes a review of all plans for young people in the centre.	The Regional Manager audit will monitor the effectiveness of interventions to support young people in attaining their Care Goals and placement plan goals.

	The manager must ensure that the purpose of the placements is reviewed and discussed with the social workers and the young people, and families where relevant; to ensure tailored planning continues to support the purpose.	The Unit manager has implemented regular reviews updates and meetings with to social workers, young people and families to discuss placement plan progress.	Measuring outcomes for young people is an integral component of governance and oversight provided by Regional Manager Audits, Client Service Manager oversight in relation to identifying trends or additional supports required and oversight by the Quality Assurance specialist in relation to compliance to best practise guidelines.
	The operational management team must take account of the balance of qualified and experienced staff and learning from recent outcomes when making decisions regarding admissions in order to inform the best mix of young people aligned to the present skill base on the team.	We will endeavour to ensure that there is a balance of qualified and experienced staff where possible in order to meet the needs of the young people within the unit.	Senior management will continue to ensure only suitably qualified staff, balanced with a mix of experienced staff are available to respond to the risk profile of the young people that are considered for admission.
	The manager must review and improve the presentation of the placement plan inclusive of consistency in the implementation of meaningful and individualised key working.	Changes to the layout and structure of placement plans will be introduced in September 2019 which will allow for a more streamlined and effective Placement Plan. Key work planning and measuring progress towards placement plan objectives will be more achievable and	A new and improved placement plan has been designed and will be introduced.

		functional with this new placement plan.	
	The external management alongside the management of the centre must complete a full evidenced review of the two most recent discharges with feedback to the team and any actions for practice outlined.	All team members attended a 2 day workshop were all aspects of work in the Centre were reviewed over the last 6 months. The placement breakdowns were reviewed with input from Senior Management and also from company Psychologist. Feedback was provided to the team. The Psychologist refreshed with the team their understanding of how to implement therapeutic interventions with young people.	Any additional resources, training needs or external support will be provided to support centre management in their work with young people in placement.
3.6	The management must ensure that the individual crisis management plans and the behaviour management plans are reviewed for content and tone to ensure they are up to date and fully geared to their intended purpose.	A monthly centre manager compliance check is in place which includes checks to ensure ICMP's BSP's etc are reviewed and updated as required.	External oversight is in place in the form of Regional Audits and CSM oversight through weekly contact with Centre Management. TCI trainers are available to support the Centre Manager on request in relation to reviewing individual crisis management plans. The company Psychologist is available on request to support centre management in reviewing Therapeutic plans or Behavioural support plans.

3.7	The management must review the centres practices in line with child protection and safeguarding policies.	Management have reviewed both safeguarding and child protection policies and have reviewed these with the centre staff team.	
	The child safeguarding statement should be forwarded to the Tusla child safeguarding compliance unit for review and feedback.	The child safeguarding statement was forwarded to the Tusla compliance unit for review.	The Child Safeguarding statement will be sent to the Tusla Compliance Unit for further review as and when required.
	The management must review the child protection reporting register to ensure it is accurately structured.	Centre management have reviewed Child protection register and updated required information.	All registers are reviewed monthly as part of Regional Manager audit.
	The management must ensure that each young person's file has the full content related to actions and outcomes completed, following a child protection notification made.	Centre Management make every effort to ensure that final outcomes in relation to CPN notifications are received from SWD and will record these as appropriate in the registers.	The Regional manager will support Centre Management in following up with SWD the closing off of CPN's.