An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 101

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Huruma Ltd**
Registered Capacity:	**Eight young people**
Type of Inspection:	**Announced**
Date of inspection:	**04th & 05th March 2020**
Registration Status:	**Registered from the 03rd of November 2019 to the 03rd of November 2022**
Inspection Team:	**Joanne Cogley** **Michael McGuigan**
Date Report Issued:	**13th October 2020**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in 2007. At the time of this inspection the centre was in its fifth registration and was in year one of the cycle. The centre was registered without attached conditions from 03rd November 2019 to the 03rd November 2022.

The centre was registered to provide an aftercare service for up to eight girls and young women between the ages of 16 and 23. The centre worked in partnership with Tusla and the aim of the service was to equip each young woman with skills for independent living and adulthood, to identify each young woman's needs and help plan for the future. At the time of inspection there were four young women living in the centre, all of whom were over eighteen years of age. The inspectors contacted the young adults in advance for written consent for their files to be reviewed as part of the inspection process. One young adult provided written consent for their files to be reviewed.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.1, 2.2, 2.3, 2.4, 2.5, 2.6
5: Leadership, Management and Governance	5.1, 5.2, 5.3, 5.4
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

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 regards to registration matters

At the time of this inspection the centre was registered from the 03rd November 2019 to the 03rd November 2022. A draft inspection report was issued to the registered provider, senior management, centre manager on the 6th April 2020 and to the relevant social work departments on the 6th April 2020. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 5th May 2020. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The report notes that the centre was not in compliance with The Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III Article 7, Staffing. However, the registered proprietor had agreed voluntarily not to take any further admissions of young people under the age of 18 until staffing levels in the centre were addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 101 without attached conditions from the 3rd of November 2019 to the 3rd of November 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5 Practices and Operational Policies
Regulation 8 Accommodation
Regulation 13 Fire Precautions
Regulation 14 Safety Precautions
Regulation 17 Records

Theme 2: Effective Care and Support

Standard 2.1 Each child's identified needs inform their placement in the residential centre.

Inspectors noted the centre had a written policy on admissions which took into account the rights of the children, the National Standards for Children's Residential Centres, 2018 (HIQA) regulations and legislation and the centre's statement of purpose. The centre manager worked with the allocated social worker to ensure prior to admission that the centre was suitable to meet the needs of the young person. A representative of the board of management also sat on the admission panel where decisions were made in relation to the suitability of referrals. Inspectors were informed that risk relating to the young person and their impact on current residents were discussed at the admissions meetings however minutes of the meetings did not reflect this. Inspectors noted there was also no formal written pre-admission risk assessment or impact risk assessment created in advance of a young person's referral being discussed at the admissions panel. The registered provider must ensure there is written evidence to support the residential centre being suitable to meet the needs of the referred young person and the current young people.

Where possible, and appropriate, young people would visit the centre in advance of moving in to become familiar with the day to day living arrangements and to meet the staff team and other young people living in the centre. Prior to admission the centre would be provided with an aftercare plan detailing the needs of the young person and would work in partnership with the young person and the allocated aftercare worker to incorporate these needs into placement planning.

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

Due to the age profile of the young people in placement, permission was sought to view files. Only one young person gave permission to inspectors to review their files therefore judgement is made based on the review of one care file only.
Due to the service offered there was no requirement for up to date care plans to be on young people's files however there were up to dare aftercare plans on file and evidence of the centre working in partnership with the aftercare worker and other allocated professionals in the best interest of the young people. The plans detailed the young person's needs and supports required and there was evidence of the young person's input. The plans reviewed in this instance did not have family input however this was at the direction of the young person. There were identified external supports in place and evidence of external professional meetings occurring on a regular basis.

There was a placement plan on file for the young person. There was evidence of the young person's input into this plan. It was however hard to determine when these plans were drawn up as there was no date on them and inspectors recommend the centre manager review this to incorporate the date the placement plan was drawn up. There was limited evidence of oversight from either centre manager or a designated other in relation to placement planning and this should be reviewed. Goals, where identified, were limited but clear and relied heavily on the young person's consent and engagement due to them being over 18.

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

The layout and design of the residential centre was suitable for providing safe and effective care for the four young people in placement at the time of inspection. Each young person had their own bedroom and arrangements were in place for safe and secure storage of their personal belongings. The centre was noted to be adequately lit, heated and ventilated. There were communal, recreational and adequately decorated outdoor areas which were well maintained. The bathroom facilities were adequate for the current residents and had been redecorated following the previous inspection. The premises was clean and well decorated. There was still an outstanding issue from the previous inspection recommendations in relation to the centre windows however the centre manager confirmed funding was in the process of being sought for this. This must be followed through on. Young people had an input

into the decorating of the centre and also displayed personal photographs within their bedrooms and photos with the staff and themselves in communal areas.

Inspectors found that the centre was compliant with the requirements of health and safety and fire safety legislation. There was a safety statement in place for the centre. Inspectors found all vehicles were taxed and insured and there were driving licences on file for staff members where appropriate.

There were procedures in place for managing the risks to the health and safety of young people, staff and visitors.

Standard 2.4 The information necessary to support the provision of child-centred, safe and effective care is available for each child in the residential centre.

Inspectors reviewed care files for young people and found that staff in the centre maintained a care record for each child in the residential centre. All records reviewed by inspectors were found to be up to date. All records were held within a locked office and young people could have access to them upon request. The centre had a system in place for archiving also.

Standard 2.5 Each child experiences integrated care which is coordinated effectively within and between services.

Inspectors found that when a young person was admitted to the centre, the referral documentation incorporated the need to have an identified discharge plan from the onset. Staff in the centre worked in conjunction with aftercare workers to ensure this was achieved. There was evidence of regular meetings with the aftercare workers and external professionals. The centre also had an outreach service attached to the organisation in which the young people were linked in with upon admission and transitioned out through to ensure continuity of care. There was clear evidence in the aftercare plan of the young person being involved in the decision making process and having an input into their placement and subsequent placements. As part of the discharge process the centre completed an end of placement report to ensure all relevant information relating to the young person is transferred following their discharge.

At the time of inspection, the centre didn't have a mechanism for seeking feedback from the young people either on a regular basis or upon discharge to assess the

effectiveness of the young person's experience of care to inform learning for future placements and the registered provider must ensure such mechanism is implemented moving forward.

Standard 2.6 Each child is supported in the transition from childhood to adulthood.

As this centre was a focused aftercare service, aftercare planning was the core function of the service. Young people had an allocated aftercare worker and aftercare plans were in place with clear input evident from the young people. Each young person had an identified key worker who they could build a relationship with and complete one to one work on a regular basis. Through interviews and from being present in the centre, Inspectors noted that it was evident that work was being completed with the young people on a daily basis however inspectors noted limited written key working documents evidencing the work around independent living and the potential emotional, physical, financial impact of leaving care. The centre manager must review current key working plans to ensure the work being completed is followed up through written documentation with centre manager oversight evident. Although it was noted that young people are offered their files to review on a regular basis, they were not offered a review of their files upon discharge nor provided with copies of important documents such as medical records, education records, birth cert etc. The centre manager must ensure young people are provided with copies of important documents upon discharge.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 2.2** **Standard 2.3** **Standard 2.4**
Practices met the required standard in some respects only	**Standard 2.1** **Standard 2.5** **Standard 2.6**
Practices did not meet the required standard	**None identified**

Actions required

- The registered provider must ensure there is written evidence to support the residential centre being suitable to meeting the needs of the referred young person and the current young people.
- The registered provider must ensure they continue to follow up on the outstanding issues from the previous inspection relating to the upgrading of windows.
- The registered provider must ensure a mechanism for seeking feedback from the young people both on a regular basis and upon discharge to assess the effectiveness of the young person's experience of care to inform learning for future placements is created and implemented
- The centre manager must review current key working plans to ensure the work being completed is followed up through written documentation with centre manager oversight evident.
- The centre manager must ensure young people are provided with copies of important documents upon discharge.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

Inspectors note for the purposes of this inspection report that the registered provider referred to throughout refers to the board of management.

The centre had policies and procedures in place. These were currently in the process of being reviewed for 2020 to ensure they complied with The National Standards for

Children's Residential Centres, 2018 (HIQA). Inspectors saw evidence that policies were reviewed at board of management meetings and also at team meetings however there was no evidence of a definite timeframe for the completion of policy review. The registered provider must ensure that all policies are reviewed in line with the National Standards for Children's Residential Centres, 2018 (HIQA) in an appropriate timeframe. Staff members interviewed demonstrated an awareness and understanding of the relevant legislation, policies and standards appropriate to their roles.

Standard 5.2

During the course of inspection, it was clearly evident that leadership was demonstrated by the centre manager. The centre manager was appropriately qualified and vetted and was present in the centre Monday to Friday. The centre's internal management structure consisted of one centre manager together with an acting deputy manager and two social care leaders, with a third social care leader position yet to be filled. Inspectors noted that there were no plans to hold interviews and appoint staff to permanent posts in the immediate future and it is recommended that the board review this to ensure all posts are permanently filled and the centre has a full staff and management compliment.

There were defined governance arrangements and structures in place. The organisation employed an external professional to complete quarterly themed audits. In addition to this the centre manager was expected to complete quarterly audits based on all themes in the National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors found that there was a significant emphasis being placed on the centre manager taking on a governance role in addition to their day to day duties. The registered provider must ensure the arrangements for the external oversight of the centre are increased and the process reviewed.

It was confirmed that when the centre manager takes annual leave, the period of leave was covered by the acting deputy manager. The centre manager confirmed that delegated tasks between themselves and the acting deputy manager were clear in job descriptions, through management meetings and through internal electronic mail system.

The centre manager confirmed there were appropriate service level agreements in place and that a bi annual report was provided to their funding bodies together with regular meetings with the area child care manager.

The centre promoted a culture of learning and this was evidenced through a review of team meetings and supervisions. All staff members had received job descriptions and were clear on their roles and responsibilities.

The centre's policies at the time of inspection required updating in line with the National Standards for Children's Residential Centres, 2018 (HIQA). The centre had a policy on risk management however inspectors noted that staff struggled to describe this in operation and were not aware of the organisational or centre specific risks. Inspectors found that the centre risk register was not a live document and did not contain certain risks that could have an impact on the operation of the centre and outcomes for young people. From a review of team meetings, management meetings and board meetings it was not evident that risk identification, assessment and management was a regular item on the agenda for discussion. The registered provider and centre manager must ensure that the current risk management process is understood and effectively implemented by staff members together with ensuring the centres risk register is utilised as a live document. The centre had procedures in place for designated people to contact in case of an emergency and operated an effective on call system.

Standard 5.3

The centre had a statement of purpose which had recently been reviewed and updated in January 2020. This statement of purpose briefly described the aims and objectives of the centre, the range of services available and the arrangements for the wellbeing and safety of children within the centre. The statement of purpose also outlined information relating to the management and staff employed in the centre. The document was also available in the young person's handbook and in the literature provided to parents. Through interview staff members demonstrated knowledge of the work that they were undertaking with the young people within the centre; however, there was no evidence of a formal model of care or specialised training being provided to underpin their work. The centre did not appear to employ a model of care that was evidence based and in line with best practise. The registered provider must ensure a formal model of care is implemented that is theoretically supported and embedded in practise, that is regularly reviewed and a training programme is provided to the staff team.

Standard 5.4

Inspectors noted there had been a move towards increased governance and quality assessment since the previous inspection. Whilst there was an improvement noted, the current system should be reviewed to reduce the expectation on the centre manager and increase the expectation on the external auditor in relation to governance and oversight. The current auditing system had been bench marked against the National Standards for Children's Residential Centres, 2018 (HIQA). The registered provider must also ensure a mechanism is implemented for an annual review of compliance to be completed either by the registered provider or the external auditor that focuses on promoting improvements in work practice and to achieve better outcomes for the residents of the centre.

From a review of complaints, inspectors noted that there was no evidence of external oversight by the registered provider. The registered provider must ensure they are overseeing complaints for recording, monitoring, action and analysis. Inspectors noted one recent complaint from a past resident was being investigated by the centre manager. This complaint was directly related to the care the young person had received during their time in the centre. Whilst the centres complaints policy does highlight that all complaints will be reviewed by the centre manager, inspectors believe for the purposes of transparency, accountability and safety, the centre manager should not investigate complaints relating to the care being provided in the centre and this should be the responsibility of an external party. The registered provider must ensure the centres complaint policy is reviewed and amended to reflect this. Social work departments or aftercare workers should be in included in investigations where appropriate.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1** **Regulation 5**

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

Actions required

- The registered provider must ensure that all policies are reviewed in line with the National Standards for Children's Residential Centres, 2018 (HIQA) in an appropriate timeframe.
- The registered provider must ensure that a review of vacant staff positions is completed and ensure all posts are filled so that the centre has a full staff and management compliment.
- The registered provider must ensure the arrangements for the external oversight of the centre are increased and the process reviewed.
- The registered provider and centre manager must ensure that the current risk management process is understood and effectively implemented by staff members together with ensuring the centres risk register is utilised as a live document.
- The registered provider must ensure a formal model of care is implemented that is theoretically supported and embedded in practise, that is regularly reviewed and a training programme is provided to the staff team.
- The registered provider must ensure a mechanism is implemented for an annual review of compliance to be completed either by the registered provider or the external auditor that focuses on promoting improvements in work practice and to achieve better outcomes for the residents of the centre.
- The registered provider must ensure they are overseeing complaints for recording, monitoring, action and analysis.
- The registered provider must ensure the centres complaint policy is reviewed.

Regulations 6 Person in Charge
Regulation 7 Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found evidence of workforce planning and issues on staff shortages being addressed in management meetings. Planning took into account management of annual leave, maternity leaves and retirements. The centre also had access to its own relief panel to cover any gaps required. The centre manager confirmed that this panel was suitably qualified and experienced. During interviews with staff members and from review of inspection questionnaires, inspectors found that staff demonstrated that they had the relevant competencies to meet the needs of the young people.

Inspectors did not find sufficient numbers of staff to meet the needs of the young people living in the centre at all times. The centres staffing numbers, at the time of inspection also did not meet the alternative care inspection and monitoring team recent service memo in relation to the required staff numbers in each individual service. The centre was required to have eight full time permanent staff members employed. At the time of inspection, the centre had six staff members on contract however due to reduced hours, these were the equivalent of five full time permanent staff members employed together with an acting deputy manager who worked Monday to Friday as support to the centre manager as opposed to direct work with the young people (both of who are not considered to form part of overall numbers). This resulted in the team having a deficit of the equivalent of three full time staff members. The deputy manager had been in an acting position for a period of time with no plans in the immediate future to interview for this position. As a result of this decision their previous role could not be backfilled and was being filled by a number of regular relief staff members. The registered provider must ensure staffing numbers are brought up to an appropriate quota as a matter of priority.

Inspectors noted that staff members in the centre had an average of 16 years service. Through interview, staff members confirmed with inspectors the main reason for staff retention was the culture promoted within the centre and the support received from the centre manager and their colleagues.

The centre had a formalised procedure for on-call arrangements at evenings and weekends.

Standard 6.2 The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

Inspectors found both the centre manager and acting deputy manager had appropriate qualifications and experience to manage the centre. Through interview with staff members, they confirmed they had all received a written job description and contract upon commencement of employment or change of roles. Inspectors found the centre had a written code of conduct and the staff members interviewed were aware of this policy together with its contents in relation to lone working, personal phone usage, photographs, boundaries in work, etc.

Inspectors found from a review of staff files that all staff members employed by the centre had personnel file allocated to them however there were some noted gaps in relation to the files. Inspectors found from the sample of files reviewed that whilst there was an application form on file, the centre did not hold CVs for staff members. Some applications forms did not contain complete records of employment and education history with gaps noted that could not be verified due to no CV being held on file.

Inspectors also noted that in some instances qualifications had not been verified with the awarding institutions. Inspectors found that references were not always from people in line management positions and one instance peer references were on file in lieu of supervisor / manager references. The registered provider must ensure that all staff are recruited in line with policy and legislation and that staff personnel files are kept up to date at all times.

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

From a review of questionnaires and staff interviews, inspectors noted that staff members were aware of and understood their roles and responsibilities within the centre. Through interview, staff in the centre expressed that they were supported by management to effectively exercise their professional judgement in order to provide safe and effective care. The centre had a number of procedures in place to protect staff members and minimise the risk to their safety. This included a suite of policies

and procedures including lone working, code of conduct, risk management together with on site CCTV. A recent escalation in a young person's behaviour saw a situation become very unsafe and the centre made the decision to discharge this young person in order to continue to maintain the safety of both staff and young people who remained in the centre.

Inspectors reviewed management meetings and team meetings, both of which occurred every two weeks. Records of attendance were documented and the level of attendance was very high. There was evidence of a culture of learning and development through these minutes. There was evidence of shared learnings on approaches used with –significant events and also where a staff member had been sent on training, this learning was brought back and presented to the team through a team meeting.

Inspectors found the centre to operate under a supervision policy which stated that all staff members will be supervised every two months for the duration of one hour. Inspectors found supervision to be occurring within the stated timeframe and being carried out by the centre manager and deputy manager. Records were signed by both staff and were held on files securely by the centre manager. It was noted that newer staff members were receiving supervision on a monthly basis as part of the induction process. Staff members who were appointed as supervisors had received supervision training prior to completing supervision with their supervisees.

Inspectors noted that centre had an appraisals policy dated the 14/1/2019, in this in was noted that a new process was being drawn up and would be completed by the end of 2019. The centre manager confirmed with inspectors that this process had now been finalised however was yet to be rolled out. The centre manager must ensure each staff members performance is formally appraised annually and a written record of this is kept on file.

The centre had a system in place for supporting staff members to manage the impact of working in the centre. Staff were able to access the organisations psychologists for support or other external holistic supports if required. These systems were supported through two organisational policies.

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

Inspectors reviewed the training schedule and found this to be forward planning for the year 2020. Training was provided to staff in all mandatory areas such as first aid, fire safety, etc. however there were some noted gaps in the training records provided to inspectors by the centre manager. There were some noted deficits in areas such as TCI and HACCP and these should be addressed as a matter of priority. It was clear from interview and review that the centre manager had full oversight of training however there was no evidence of the registered provider undertaking a regular training needs analysis. There was evidence of the centre manager raising training needs at board level but there was no evidence of solution focused responses or actions emulating from this. Staff members in interview noted with inspectors that there had been a significant decrease in the availability of specialist training to them in the past year. The registered provider must ensure there is a programme of training and continuous professional development to ensure that staff at all levels maintain competence in relevant areas. From a review of files and through interviews inspectors found inductions were occurring and these were supported through a policy.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 6.2** **Standard 6.3** **Standard 6.4**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The registered provider must ensure staffing numbers are brought up to an appropriate quota as a matter of priority.

- The registered provider must ensure that all staff are recruited in line with policy and legislation and that staff personnel files are kept up to date at all times.
- The centre manager must ensure each staff member's performance is formally appraised annually and a written record of this is kept on file.
- The registered provider must ensure the current system for supporting staff to manage the impact of working in the centre is a formalised system and a policy is implemented to support the system.
- The registered provider must ensure there is a programme of training and continuous professional development to ensure that staff at all levels maintain competence in relevant areas.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered provider must ensure there is written evidence to support the residential centre being suitable to meeting the needs of the referred young person and the current young people.	A pre-admission Impact Risk Assessment form has been designed and completed as part of a recent admissions meeting. This will now form part of the centre's admission's procedure to identify the needs of the young person being referred to the service.	The Deputy Manager has been delegated with this role with oversight from the Manager and this will be completed following each admission meeting.
	The registered provider must ensure they continue to follow up on the outstanding issues from the previous inspection relating to the upgrading of windows.	After exhausting the funding options available to us i.e. The Sisters of Mercy Provincial Team and we also submitted a capital fund application to TUSLA both were declined, an application for a capital grant for Community Groups was submitted to Cork City Council on the 21st February 2020. The funding is through a Community Development capital grant for works of a capital or building maintenance nature.	The Manager and Deputy Manager continue to keep this item live on the Board Meeting Agendas.

		The application made a request for the refurbishment of the windows in the centre as a matter of urgency. We are currently awaiting a response from Cork City Council.	
	The registered provider must ensure a mechanism for seeking feedback from the young people both on a regular basis and upon discharge to assess the effectiveness of the young person's experience of care to inform learning for future placements is created and implemented	Community Meetings take place weekly in the centre and minutes are kept to ensure we are continually receiving feedback form the young people in our service. There is a staff member assigned with the task of completing exit interviews with young people who have left the service in the last 6 months to a year. There is an existing template for exit interviews in place.	All pending exit interviews will be completed by the end of May.
	The centre manager must review current key working plans to ensure the work being completed is followed up through written documentation with centre manager oversight evident.	The Manager signs all paperwork in the centre including key-working sessions and placement plan updates. Regular case management meetings between the Manager, Deputy Manager and the keyworker are taking place, which are	Documentation practices and the development of these to be reviewed and resume post Covid-19.

		minuted in each young person's case management book. Feedback on key-working plans is given at this point to the keyworker. The decisions made are then circulated to the staff team. Keyworkers are tasked with updating placement plans and informing the Manager of these updates.	
	The centre manager must ensure young people are provided with copies of important documents upon discharge.	This has been added to the Key-work checklist as a reminder to each keyworker to offer these documents to the young person on discharge. This is also recorded on the 'young person's discharge from the centre to Outreach Services Form'.	The manager oversees the final draft of the 'young person's discharge from the centre to outreach' form and ensures there is follow through on this step.
5	The registered provider must ensure that all policies are reviewed in line with the National Standards for Children's Residential Centres, 2018 (HIQA) in an appropriate timeframe.	A plan is being put in place to review the centre policies and procedures annually as opposed to at each Board meeting. This has been discussed with the Board of Trustees who have agreed an annual review of policies and procedures will be put in place.	The Board of Directors have agreed to hold an additional Board meeting annually to address this process efficiently. A date will be agreed on to satisfy this recommendation. Current Policy review to be complete by May 31st 2020.

	The registered provider must ensure that a review of vacant staff positions is completed and ensure all posts are filled so that the centre has a full staff and management compliment.	A business case has been sent to TUSLA in relation to securing extra funding for vacant posts.	A meeting is to take place between the Manager of centre, the Board of Directors, the Childcare Manager, the Area manager and the Commissioning Area Manager for TUSLA. A date is not confirmed as of yet due to the restriction's in place at present re: Covid-19.
	The registered provider must ensure the arrangements for the external oversight of the centre are increased and the process reviewed.	Currently a quarterly audit takes place facilitated by an external auditor (Social Care practitioner). A business case has been prepared and put forward to address gaps in the governance and management structure in the centre. This has been forwarded to the Regional Office on the 27.04.2020.	A meeting is to take place between the Manager of the centre, the Board of Directors, the Childcare Manager, the Area manager and the Commissioning Area Manager for TUSLA. A date is not confirmed as of yet due to the restriction's in place at present re Covid-19.
	The registered provider and centre manager must ensure that the current risk management process is understood and effectively implemented by staff members together with ensuring the centres risk register is utilised as a live document.	Risk register has been updated to include the recommendations suggested by the Inspectorate. It is a live document as recommended by the Inspectorate. The staff team are emailed with any updates regarding the service risk register.	This will be reviewed annually at team meetings and each time there is an update to the risk register it will be e-mailed around to the staff team for their viewing and input. It will be added to management meeting agendas also.

	The registered provider must ensure a formal model of care is implemented that is theoretically supported and embedded in practise, that is regularly reviewed and a training programme is provided to the staff team.	A Model of care is currently in draft form, completed by the Manager. The service model of care is integrative and relationship based and it draws on a number of theoretical frameworks.	Once finalised a training programme for the team will be drawn up added to the training schedule and will form part of the staff induction process to give a clear understanding of how the practices of the service are guided and informed. The final draft of model of care will have oversight from our consultant psychologist and it is hoped this will be completed by the end of June 2020 with a training programme in place.
	The registered provider must ensure a mechanism is implemented for an annual review of compliance to be completed either by the registered provider or the external auditor that focuses on promoting improvements in work practice and to achieve better outcomes for the residents of the centre.	An annual review template to be designed by the registered provider. Template to be completed by end of May. A KPI system has been designed and implemented by the manger this is presented to the board quarterly.	It will be completed and presented to the Board annually.
	The registered provider must ensure they are overseeing complaints for	The Board have appointed an external auditor who performs quarterly audits and	This has been added to the agenda for Board meetings.

	recording, monitoring, action and analysis. The registered provider must ensure the centres complaint policy is reviewed.	presents them to the Board. This covers Complaints. The registered provider will provide feedback at Board meeting in relation to any comments /concerns they may have. Complaints policy will be reviewed by the end of May.	
6	The registered provider must ensure staffing numbers are brought up to an appropriate quota as a matter of priority. The registered provider must ensure that all staff are recruited in line with policy and legislation and that all staff personnel files are kept up to date at all times.	A business case has been prepared and put forward to address gaps in the staffing compliment in the centre. This has been forwarded to the Regional Office on the 27.04.2020. Gaps in current staff files for newer staff have been followed up on.	A meeting is to take place between the Manager of the centre, the Board of Directors, the Childcare Manager, the Area manager and the Commissioning Area Manager for TUSLA. A date is not confirmed as of yet due to the restriction's in place at present re Covid-19. Induction checklist to include a copy of CV's to identify staff service history and any gaps and verification of qualifications through the awarding institutions.

	The centre manager must ensure each staff members performance is formally appraised annually and a written record of this is kept on file.	Appraisal system in place with a schedule for the staff team. Each staff member carrying out the appraisal has been assigned a number of staff to appraise. It is hoped this will be completed by June 2020 however this depends on factors relating to covid-19 and social distancing measures. We are currently working on a 1 staff basis.	System in place.
	The registered provider must ensure there is a programme of training and continuous professional development to ensure that staff at all levels maintain competence in relevant areas.	There is a current training programme in place for the year ahead. This addresses compulsory training for the staff team. At times where the need arises we will nominate a member of the team to go to a specific training if it is felt it can enhance our practice.	All staff are aware of these policies and the support available to them internally and externally.
		We do not have the funding to cover staff training costs therefore; we prioritise mandatory training at specific times in the year with the result that there may be a delay in newer staff members being trained. Training costs resulted in a -15,000 deficit in our 2019 budget.	Cork City Partnership were contacted in February as a possible funder for the training in the centre. This was declined. Training and the need for an allocated budget will continue to be discussed at Board Meetings. This will also be discussed at the regional meeting between

			the Board, TUSLA and the Manager of the centre. A yearly training report is completed and will include a training needs analysis going forward.