An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 103

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Daffodil Care Services Ltd**
Registered Capacity:	**Six young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**14th & 15th March 2022**
Registration Status:	**Registered from the 3rd of March 2021 to the 3rd of March 2024**
Inspection Team:	**Eileen Woods** **Lisa Tobin**
Date Report Issued:	**16th June 2022**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 3rd of March 2015. At the time of this inspection the centre was in its third registration and beginning year two of the cycle. The centre was registered without attached conditions from 3rd of March 2021 to the 3rd of March 2024.

The centre was registered to provide multiple occupancy for up to six young people aged from sixteen to nineteen years. There is a requirement to be under eighteen upon admission unless a derogation to the purpose and function is sought from the Tusla ACIMS, alternative care inspection and monitoring service, registration panel. This has occurred twice since the last inspection in January 2021. Placements were on a short to medium term basis in a semi-independent style setting. Young people had their own apartments, and the aim of the service was to prepare young people for leaving care, provide them with life skills and support their transition to independent living. The centre operated the STEM (Systemic Therapeutic Engagement Model) model of care. This is a combination of theories and proposed practices that draws on a number of complementary philosophies and approaches including circle of courage, response abilities pathways, therapeutic crisis intervention and daily life events.
There were two young people under eighteen and two over eighteen living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

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

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant

professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 5th of May 2022 and to the relevant social work departments on the 5th of May 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 18th of May 2022. This was deemed to require further detail and the inspection service received satisfactory evidence of the issues addressed and in process by the 25th of May 2022.

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: 103 without attached conditions from the 3rd of March 2021 to the 3rd of March 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 1: Child-centred Care and Support

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

This centre had a variety of ways for creating opportunities for young people to participate in their placements in line with their age range as older teenagers. These included monthly meetings to set goals with their key worker, the option of one-to-one time with staff including their key worker, recording of their voice and comments in the daily logs, open access to the centre manager and regular visits from the regional manager. All the young people were offered access to read their records with the centre manager by appointment. The centre manager collated the young people's voice from the daily logs and relayed this information to the regional manager in a fortnightly governance report.

Young people's meetings were offered weekly, attendance rates could be low at these depending on the residents at that time. There was a young person's information booklet in place. The booklet was completed with young people upon admission and a copy provided for them to have. The booklet as currently constructed did not present as having been reviewed or informed directly by young people, it read as focused on an explanation of the model of care to the exclusion of a description of the strengths and supports on offer in this centre. The booklet overall therefore did not read as congruent with the general practices of the staff and management. Inspectors recommend that the booklet be reviewed and updated taking account of young people's input about what was valuable for them to know as well as keeping what was essential for the centre to let them know.

The young people's meeting records evidenced that the staff focused on including topics and items of interest as well as trying to gain the young people's input on daily living matters like food choices. The young peoples meeting records displayed a focus on trying to get young people to engage in their programmes and informing them about life skills, for example how to deal with conflict in the group and avoid escalations that might lead to bullying. There were recurring themes in the young

people's meeting records around non-engagement in their placement plans and agendas were often therefore weighted towards a teaching approach. It would be positive to see the format reviewed from a perspective of what works and not and to gain young people's feedback on what they might want or like to see happen around young people's meetings.

There was no direct contact between the centre and the families of the current four young people. Two were over eighteen and two were under eighteen. Their social workers or the young adults themselves communicated with families and inspectors were not provided with options for family feedback on this occasion. There was a booklet for parent's which inspectors found did not refer to a complaints option or process for family and must be updated to include this.

The centre's complaints policy was structured to account for immediate formal complaints as well as local, centre based, resolvable complaints. There were procedures for both with the named objectives being systems for hearing, responding to, addressing and learning from complaints of all types. The centres goals for the young people were for them to see fairness and problem solving modelled. The wider goals for the company were also named and these were to have learning, for example regarding the effectiveness of their model of care, their model of listening to young people through to the quality and upkeep of their properties and services for children. There were categories for reporting complaints upwards through the service reporting mechanisms and through the auditing system. There was evidence that some difficulties in capturing, recording and tracking at centre level had resulted in poor evidence that the overarching goals of the complaints policy, as listed here, were being achieved.

Local centre complaints were not being consistently captured in the manner intended by the policy and procedure. Those that were captured evidenced a commitment to conflict resolution and modelling for life skills and were well done. The register in place did not capture all those being addressed also and there was no structure through which the team could currently check where their gaps might be in capturing informal complaints. The register itself was a limited format that should be improved in order to support team development and information flow through the centre and organisation. The centre manager had been operating with deficits in staffing consistently for the second half of 2021 and ongoing, recruitment had been taking place but not all persons offered posts had ultimately taken them up. The centre manager and their regional manager with the support of the senior management team put contingencies in place to mediate the impact of this. Staffing alongside

increased covid related sick leave had resulted in an increased workload on the centre manager and resultant gaps in recording, the centre manager named this and the inspectors acknowledge it. The staffing issues placed the centre not in compliance with the requirements of the regulation 7: staffing as set out in the relevant Tusla staffing memo which states that a social care manager plus eight staff is the minimum required number to operate a service. The centre had seven full time staff at the date of inspection visit. During this inspection process the matter was escalated to Tusla ACIMS management and the centre's manager and the director of operations updated the inspection team on improvements. By the time of the completion of the inspection process the staffing had been rectified and the appropriate numbers of staff were in full time posts. The company must ensure that they maintain compliance with the regulations and must inform the relevant ACIMS management where compliance with staffing numbers falls consistently below the requirements.

There were registers in place for local and for formal complaints there had been no formal complaints entered onto this register since May of 2020. The informal complaints register had entries up to January 2022 and both registers evidenced oversight by the centre manager, the regional manager and the director of operations. There were also regular internal centre audits of complaints and child protection. The registers were not well structured to reflect the complaints process. The registers in general were handwritten and hard to read, therefore these must be improved so that the link from issues and complaints raised through to the relevant process is evidenced. Also, the outcomes inclusive of a young persons view and the external and internal learning for practice were not consistently apparent in the registers, operational reports or audits.

Two young people met inspectors and one noted that overall, they could safely raise issues that were then responded to fairly. A second young person raised significant dissatisfaction with their experiences in care related to being heard, their experience of fairness from the centre and the social work department and of the support on offer at the centre. They sent these directly to the inspectors. They stated that they had raised issues before and that not all had been responded to fully. Inspectors found that for this young person that there were decisions made by the social work department together with the centre that added to their sense of disillusionment with the residential care experience and that they found hard to follow the rationale for. A number of their ongoing complaints and concerns were being responded to as they arose but not being consistently captured and responded to cohesively within the available systems at the centre. There had been a significant gap in timeframes both externally and internally to gain specialist guidance in supporting them and in direct

options for counselling and support for them from the centre and from the social work department. Inspectors forwarded a record of the complaints raised to the centre and to the social work department and inspectors will track the process and outcomes for these complaints.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management team must review the young people's booklets to ensure that it is informed by young people's views and needs.
- The centre management must review the structure of the young people's meetings to increase opportunities for young person led engagement and support.
- The organisational management must ensure that there is an up-to-date parents leaflet, that the leaflet is circulated to parents and contains information on complaints.
- The centre management and organisational management must review the formats for the registers for complaints and ensure that they reflect the procedures and stages through to outcomes.
- The organisational management must review and address how they support the centre with complex cases and complex needs to increase opportunities for team advice.
- The centre management must record and respond to the complaints notified to them by a young person.
- The organisational management must ensure that outcomes from complaints are evidenced as informing learning and improvements in practices as

relevant to this centre. Examples of this in practice must be provided in response to this report.

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

Theme 3: Safe Care and Support

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

The company had a suite of policies in place that were in line with Children First: National Guidance for the Protection and Welfare of Children 2017 and the relevant national guidelines and legislation. The policies included child protection and safeguarding, anti-bullying, risk assessment and management and the centre had a compliant child safeguarding statement in place. The policies had been reviewed yearly and/or as required and were evidenced as discussed regularly on team meeting agendas. The staff displayed good knowledge regarding their role under Children First as mandated persons, they were clear on reporting procedures, the roles of DLP (designated liaison person) and DDLP and on anti-bullying strategies. Inspectors found that the team needed to familiarise themselves on the child safeguarding statement regarding its purpose and content. Inspectors found also that staff were not fully aware of the content of the protected disclosures policy. There was a policy and training provided on anti-bullying and there were no current incidents of bullying at the centre.

There were avenues for recording and monitoring of concerns and child protection matters through team meetings, the fortnightly governance reports and through a dedicated monthly audit of child protection completed by the centre manager. Child protection and welfare reports when notified through the Tusla portal for reporting concerns were entered onto the centre significant event register, the portal reporting number was not recorded on this register but was maintained by the centre manager in a folder. Inspectors recommend that the centre consider introducing a dedicated child protection register to support tracking of reports and as a reflection of children first specific procedures. The centre manager maintained a folder of child protection reports made and the last one was listed as made in November 2020. The system as currently arranged resulted in the manager maintaining a folder of information on child protection matters that were acted upon and closed. A re-

organisation of the current system would benefit how and when confidential information was stored and then filed with the relevant young persons file. Maintaining a register would assist the management in creating a more effective system for recording, tracking, closing and filing child protection and welfare matters.

The director of operations outlined for inspectors a national plan in place by the company to address external auditing, its regularity and impact and that they had communications with Tusla ACIMS regarding the operational plan. A copy of a revised 2022 external auditing schedule for the centre was provided to inspectors.

The centre maintained a training audit and this listed all staff as having completed or renewed their Children First mandatory eLearning module in line with the requisite timeframes of every three years. The staff had also completed, were booked for or had renewed their organisation's child protection policy and procedure training in line with their policy of minimum two yearly.

Inspectors found that the local garda division were routinely alerted to new admissions to the centre and this must desist unless indicated as necessary due to bail conditions, missing child in care risks or child sexual exploitation risks in line with national Child and Family Agency and An Garda Siochana agreed protocols.

The centre manager completed a monthly internal audit on risk, child protection and complaints, the regional manager had completed their own child protection audit in December 2021 with one issue noted for action at that time. Inspectors found that the routine of repeated use of this monthly audit did not act to generate actions or review by identifying gaps. It was found that the fortnightly governance report completed by the centre manager was of a good standard regarding tracking and did it more effectively, with quality assurance follow up by the regional manager. The monthly risk audit did not explore the high levels of absence at risk being reported for example as it did not track concerns under the threshold. It is important that the audits and templates in place do not become administrative or routine but do act as effective additional avenues to help inform the centre management on adapting strategy and practice in a way that could be most useful to them.

There were a range of risks and vulnerabilities being exhibited and experienced by some of the young people. There was evidence of the centre manager co-ordinating robust effective work surrounding a number of complex areas. They participated in regular professionals and strategy meetings bringing the agreements made at those

back to the planning at the centre and to the young people. The staff had completed some additional training in areas such as substance misuse to help inform the direct work with the young people.

The inspectors found that decisions made with a social work department around the use of the risk categorisation of 'absence at risk' as opposed to the Garda and Tusla missing child in care reporting had presented problems over time. The reporting protocol is outlined in the Joint Protocol between An Garda Siochana and the Health Services Executive Children and Family Services 2012 and it removed the absent at risk approach to ensure a young person is either absent without permission or missing from care. It had been the agreed strategy between the social work department and the centre to take an 'at risk' approach and had worked to include the young person in the approach in order to build trust. The resulting outcome did not support that the strategy was successful overall and had continued when perhaps it should not. The centre did risk assess each absence and did so with recourse to previous agreements and absence management plans derived from those agreements but must alert referring areas and young people that where they deem it necessary, they will report young people as missing child from care. The centre must track concerns arising from absences and utilise this information to inform decision making at centre level.

There was evidence of work undertaken with young people in line with the purpose and function on their areas of individualised vulnerabilities including preparation for leaving care. There was support for young people undertaking exams, on training courses and in employment. Inspectors found evidence that the staff team were skilled at anti bullying awareness or potential for group impact and acted to mitigate around these risks effectively. There was regular review of individual crisis support plans, absence management plans and placement plans to inform direct work. Inspectors found in the samples reviewed that there was low recorded evidence of work on cyber safety and awareness and of an over reliance on the life space interview tool after each absence even where it was repeatedly not engaged with. A key area of vulnerability for young people, identified by the team, was low engagement or low motivation around preparation for leaving care. This information could inform service development plans or programme development for the centre.

There were no child protection reports made since the last inspection in January 2021 so the informing of parents was not an issue. It was not apparent what arrangements or agreements were in place regarding informing parents. Inspectors could see no procedure within the child protection and safeguarding policy to explain

who may, or what persons would decide, and how, regarding the appropriate sharing of information with parents.

There was a policy available on protected disclosures and as stated the team must review again the distinction between child protection reporting, the protected disclosures policy and the child safeguarding statement.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must revise with the team their knowledge of the child safeguarding statement inclusive of its purpose and content. The team must also review and clarify their knowledge of the protected disclosures policy.
- The organisational management and policy group must review the child protection and safeguarding policy to ensure there is clear reference to informing parents or guardians to ensure that at centre level staff know who will take responsibility for this.
- The centre management team must review the missing child from care protocol and absences policy and practice including the efficacy of the follow up procedures in decreasing absences where this is an issue for a young person.
- The organisational management must ensure that the revised auditing structure is implemented and supports the operational needs of the centre in identifying service strengths and needs.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

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

The young people were all over sixteen, two were over eighteen, and accessed health care independently where they wished to do so. All four young people were registered with a GP practice and where possible maintained their existing GP if distance allowed. The team created schedules of health and medical needs from existing care plans, aftercare plans and by collaboration with the young people themselves. The inspectors did not find up to date copies of all aftercare plans on file and the centre must follow up on same to ensure the young people and they have the most current documents where available. The preparation for leaving care work included health care skills and awareness inclusive of sexual health and development. Inspectors found that cultural and ethnic heritage and identity was not prominently considered on some care plans and aftercare plans by the social work department and left an important gap regarding a core area of a young person's life. This must be addressed by the Child and Family Agency and the centre can play a role in noting deficits in care plans back to social workers when they receive them.

Inspectors found that the team provided good support for healthcare appointments and attendance for treatment. The team sought to encourage attendance for specialist mental health appointments, but not all young people availed of this. The team were integral to managing complex mental health issues with young people and the centre manager and key workers worked with multi-disciplinary groups in this planning. Where young people were reluctant to access for example CAMHS inspectors found that other options were explored with and by social work departments. It was found that funding and sourcing were slow and there were impacts on timeframes from the phases of the pandemic also. A young person stated that they found that their mental health needs were not responded to in a way that they expected from the care system overall. Inspectors noted that although the company names a clinical and therapeutic approach inclusive of access on occasion to a psychologist that this did not occur even on a one off team consultation basis for any of the young people. This presented as a key aspect potentially left unexplored in the teams work to try to engage young people, who have complex issues and concerns, where they are unsure about external therapeutic options.

Staff were trained in the safe administration of medication, three day first aid response/FAR and in the use of ligature cutters. The staff had trained in the model of care and some had completed Safe Talk and Assist the two components of the national suicide awareness approach. There were policies in place for physical health, medication management, drugs and alcohol, self injury and ligature use, there was also a policy on clinical governance.

Inspectors found that the young people medical folders required attention in order to update the dating and type of medications that were current and to in general tidy and organise these files. The team carried out daily counting of medication and planned for and recorded all this activity on their handovers or the individual daily logs as required. They recorded the administration of medication and completed risk assessments for young people holding some of their own medications. These records were well maintained by the centre team. There was no company process for medication auditing and this should be considered as part of general organisational governance of medication management.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre team must ensure that the young peoples medical and health files are well maintained, clear and up to date.
- The registered proprietor must consider how they deliver on their therapeutic commitments and thresholds for additional expert advice. They must also consider how they will structure governance in medicines management.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre management team must review the young people's booklets to ensure that it is informed by young people's views and needs.	Centre management team will review the young person's handbook in conjunction with young people on site by the 30.06.2022. Booklets will be updated accordingly.	Regional Manager will review with centre management team and Senior management team for final sign off.
	The centre management must review the structure of the young people's meetings to increase opportunities for young person led engagement and support.	Centre management has reviewed young people's centre meetings and discussed same with the young people in semi-independent setting. It is proposed as per young people's voice that the meetings occur on a one to one basis as they do not wish to sit together. This will commence as of 25.05.2022 and will be completed weekly.	Centre management has reviewed young people's centre meetings and discussed same with young people in semi-independent setting. The meetings will occur on a one to one basis. This will commence 25.05.2022.
	The organisational management must ensure that there is an up to date parents leaflet, that the leaflet is	The parent's leaflet, inclusive of information on complaints, has been updated. This updated leaflet has been	As per organisational policy and procedure review mechanism, these documents are reviewed every two years and as such will

	circulated to parents and contains information on complaints.	sent to parents.	be reviewed again in 2024.
	The centre management and organisational management must review the formats for the registers for complaints and ensure that they reflect the procedures and stages through to outcomes.	Senior management team are reviewing potential of moving complaints registers online to facilitate a more flexible approach to inputting information as advised by the inspectorate. Centres provide a detailed account of complaints management through their centre monthly reports which facilitate oversight and adherence to process.	Senior management team are reviewing registers with a view to allowing them to go on line. Centre monthly reports provide a detailed account of complaints management and are discussed at monthly senior management meetings.
	The organisational management must review and address how they support the centre with complex cases and complex needs to increase opportunities for team advice.	Senior management has approved and secured training to support and address Complex cases that present to our services. The Regional Manager is booked to complete training in DDP and PACE in June and September this year and this will then be included in training provided to staff across the organisation. Support for young people will continue to be advocated for through CICR and other meetings with professionals.	Training will be completed by regional manager in June and September 2022 and absorbed into Daffodil care services STEM training to ensure an organisational impact.

	The centre management must record and respond to the complaints notified to them by a young person.	A complaints process was initiated, evidence gathered and actions and follow up agreed. Options and supports were made available for the young person to avail of when they wish to do so. There have been actions taken to complete with the team and the senior management team will sign off on the ultimate outcome when the young person responds or in such time as is reasonable to do so if they decline to participate further.	The Senior Management Team will track these complaints through to conclusion.
	The organisational management must ensure that outcomes from complaints are evidenced as informing learning and improvements in practices as relevant to this centre. Examples of this in practice must be provided in response to this report.	Centre management will continue to follow the organisation complaints policy and procedure for both informal and formal complaints. Regional manager will complete presentation on Complaints power point presentation with staff team to ensure that all are well versed in the process and timeframes required for all complaints. Presentation to be complete by 30.06.2022. Centre management and senior management team will continue to	Regional manager will complete presentation on Complaints power point presentation with staff team to ensure that all are well versed in the process and timeframes required for all complaints. Presentation to be complete by 30.06.2022 and will complete annually. Regional management and Centre management will ensure that outcomes

		monitor and review the complaints process. Centre management will ensure that outcomes from review of complaints are clearly documented in SERG reports on a monthly basis and will ensure that learning and improvements in practice are discussed at team meetings. Changes have been made - following external and internal reviews are considered by the Senior Management Team and changes implemented across the services as required. This includes, for example, a change in training requirements (Tusla's eLearning Child First training being refreshed on a three yearly basis), development of Risk Training (to support staff teams in identifying risks and how to respond to them) and a revision of documents to evidence oversight (including the introduction of the SMT centre monitoring report).	from review of complaints are clearly discussed, documented and actioned in SERG reports on a monthly basis and shared with teams at team meetings.
3	The centre management must revise with the team their knowledge of the child safeguarding statement inclusive	Centre management will review the centre safeguarding statement with all current and new staff by the 01.06.2022.	Senior management and director of service will continue with annual review and sign off of centre safeguarding statement. This

	of its purpose and content. The team must also review and clarify their knowledge of the protected disclosures policy.	Centre management will review the protected disclosures policy with all current and new staff by the 01.06.2022.	review will prompt discussion at team meeting. Regional manager will review again the protected disclosures policy at regional meeting on the 27.05.2022.
	The organisational management and policy group must review the child protection and safeguarding policy to ensure there is clear reference to informing parents or guardians to ensure that at centre level staff know who will take responsibility for this.	The senior management team will review the child protection and safeguarding policy and ensure there is clear reference to informing parents or guardians. Review to be completed by 30.07.2022. The reviewed policy will be discussed at team meeting.	Senior management team will review child protection and safeguarding policy and ensure there is clear reference to informing parents or guardians. Review to be completed by 30.07.2022.
	The centre management team must review the missing child from care protocol and absences policy and practice including the efficacy of the follow up procedures in decreasing absences where this is an issue for a young person.	Centre management team will review the missing child from care protocol and absences policy by the 30.05.2022.	
	The organisational management must ensure that the revised auditing	Organisational management have ensured that the revised auditing schedule is	Organisational auditing schedule is in place and under review by senior

	schedule is implemented and supports the operational needs of the centre in identifying service strengths and needs.	implemented and is currently underway and under review to ensure that operational needs are factored in.	management to ensure it supports the operational needs of the centre.
4	The centre team must ensure that the young people's medical and health files are well maintained, clear and up to date.	Centre team reviewed all medication files and discussed in team meeting the importance of attention to detail. Weekly reviews on medical files are being conducted by DSCM and reviewed by SCM. Medication folders and all medication checked by staff coming on and off each morning as part of handover. At present SCM or DSCM present for handover.	Regional management will conduct Medication audit as audit schedule in conjunction with Quality Assurance dept and senior management oversight.
	The registered proprietor must consider how they deliver on their therapeutic commitments and thresholds for additional expert advice. They must also consider how they will structure governance in medicines management.	Senior management utilises a number of mechanisms to ensure that additional expert advice is deployed as required. The service has access to a Clinical Psychologist as required. Review meetings and needs assessments also inform the need for expert advice and regional management in addition to centre management play a role in advocating for additional expert advice.	DDP training will be completed by regional manager in June and September 2022 and absorbed into Daffodil care services STEM training to ensure an organisational impact

		Senior management has approved and secured training to support and address Complex cases that present to our services. The Regional Manager is booked to complete training in DDP and PACE in June and September this year and this will then be included in training provided to staff across the organisation Medicines management will be completed daily by staff and SCM or DSCM will complete an audit each week on medications.	Regional management will also complete regular medication audits.