An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 119

Year: 2019

Alternative Care Inspection and Monitoring Service
Tusla - Child and Family Agency
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Registration and Inspection Report

Inspection Year:	**2019**
Name of Organisation:	**Fresh Start Ltd**
Registered Capacity:	**One young person**
Dates of Inspection:	**19th, 20th & 21st of June 2019**
Registration Status:	**Registered with attached conditions from the 23rd of September 2019 to the 23rd of September 2022**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**2nd December 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 on the 23rd of September 2016. At the time of this inspection the centre was in their first registration and was in year three of the cycle. The centre was registered without conditions from the 23rd of September 2016 to the 23rd of September 2019.

The centre's purpose and function was for single occupancy between the ages of thirteen to seventeen upon admission on a short term basis. A derogation was sought and approved for a young person outside that age range until such time as they aged in the registered age range. Their model of care was displayed in the staff office and named that the approach was individualised care within a context of assessment, evaluation and formulation followed by placement planning and goal setting as advised by a multidisciplinary team. The social worker stated that the single occupancy placement was still required as the best option for the young person and that this is kept under review at statutory review meetings and at the regular professionals meetings.

The inspectors examined aspects of standard 2 'management and staffing', standard 4 'children's rights', standard 7 'safeguarding and child protection', standard 8 'education', standard 9 'health' and standard 10 'premises and safety' of the National Standards For Children's Residential Centres, 2001. This inspection was announced and took place on the 19th, 20th and 21st of June 2019.

1.2 Methodology

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

- An examination of pre-inspection questionnaire and related documentation completed by the manager
- An examination of the questionnaires completed by:
    a) Nine of the social care staff
    b) The young person residing in the centre
    c) The social worker with responsibility for the young person

- A visual inspection of the premises and grounds guided by an audit checklist devised by the Health and Safety and Fire and Safety officers of HSE on our behalf.
- An examination of the centre's files and recording process.
    - young person's care records
    - daily logs
    - young person's meetings
    - 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
    - team meeting records
    - maintenance records
    - fire register
    - health and safety records
    - personnel files x 2 new staff
- 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 operations manager for the organisation
    c) The quality assurance and practice manager for the organisation
    d) Two social care staff
    e) The young person

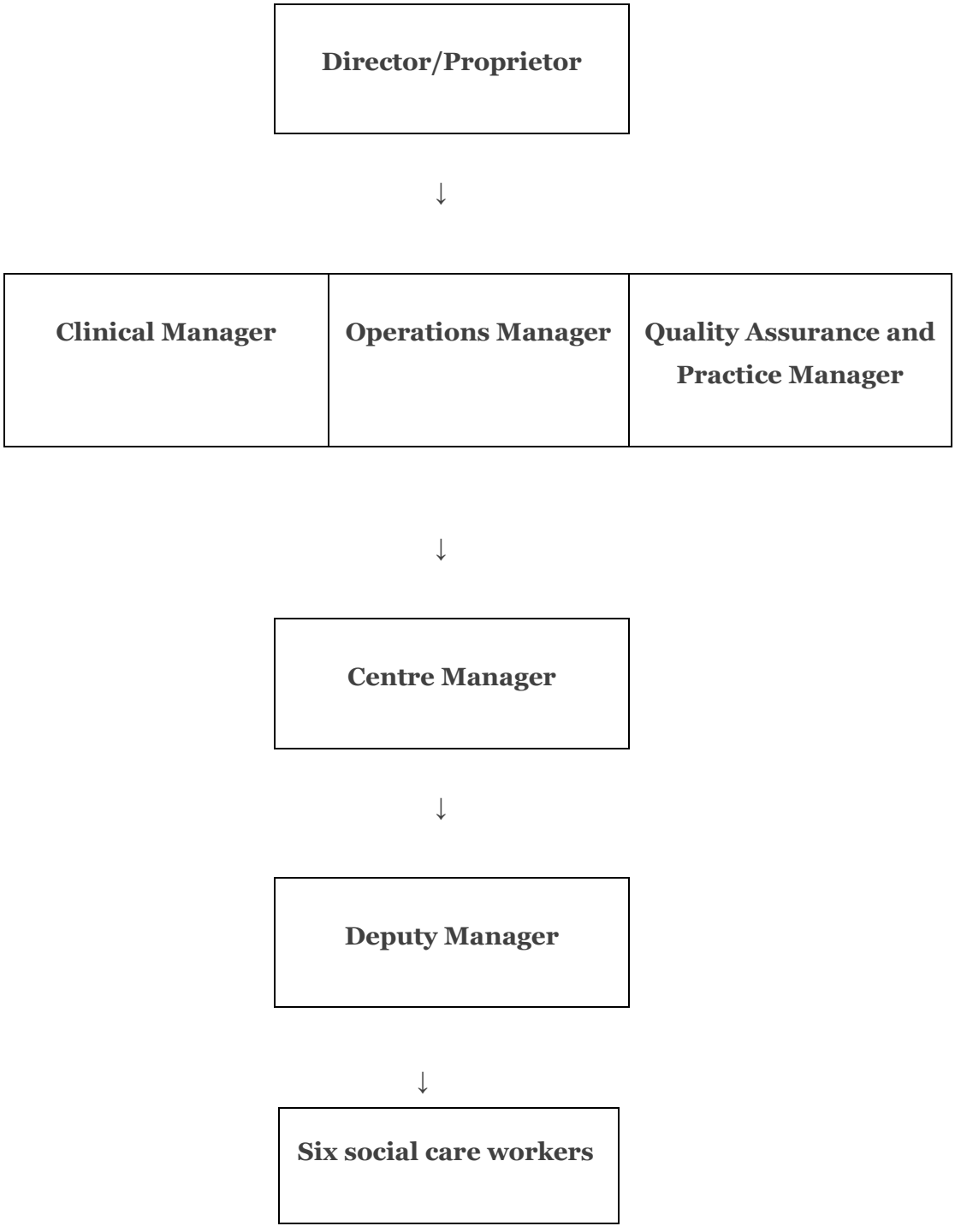
f) Phone call with the Director of the company.
g) The social worker and social work team leader for the young person residing at the centre
h) The HSE regional maintenance team leader
i) The Tusla estates manager

- Observations of care practice routines and the staff/young person's interactions. Inspectors engaged in activities with the young person and staff.

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 person, staff, management and others for their assistance throughout the inspection process.

1.3 Organisational Structure



2. Findings with regard to registration matters – pending

A draft inspection report was issued to the centre manager, director of services and the relevant social work department on the 21st of August 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 completed action plan (CAPA) on the 5th of September 2019 and the inspection service sought further details from the director. Following a period of consultation an action plan for the property was agreed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be not 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: 119 with attached conditions from the 23rd of September 2019 to the 23rd of September 2022 pursuant to Part VIII, 1991 Child Care Act.

The following condition was attached to the centres registration under Part VIII, Article 61, (5) (b) (I) (II) of the Child Care Act 1991, at that time. The condition being that:

1. A suitable property must be sourced from which to operate this centre by the 1st of March 2020.

The period of registration being from the 23rd of September 2019 to the 23rd of September 2022.

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

None identified.

3.2.2 Practices that met the required standard in some respect only

Management

This centre was last inspected in May 2018. A new manager started on the 22nd of April 2019, they had the requisite qualifications and experience for the role, and they completed recruitment and induction processes and had a signed contract on file for this post. Inspectors found that the manager was knowledgeable about governance and management procedures, they had a clear vision and plan of action which inspectors found was incrementally becoming operational. The new manager was evidenced as initiating a review of care file contents, registers and daily planning documents. They had reviewed an amount of these with some items still pending at the time of this inspection. The manager had utilised a prioritisation of work approach and should document this to track their progression through the key areas identified and assign timeframes for areas of priority. The manager stated that they had been supported by line management and the director, and had been mentored by existing managers within the company; this was to be an ongoing support for them.

There was a house manager folder in operation and this contained the monthly checklists that were completed and submitted by managers. Although some months were quiet others reflected a complex set of care needs that required regular risk review and interdisciplinary working arrangements. For example, in March the local Gardaí had been to the centre three times and had requested a meeting regarding the risk to public safety on the road outside the centre. This meeting was still pending at the time of the inspection and inspectors have requested that the new manager expedite arranging a meeting with the Gardaí, the social worker, the GAL and senior management. The social work department had named their concerns about this issue and had ongoing discussions with the management about this and other areas of risk.

When inspectors met with the social worker and the social work team leader they confirmed that arrangements were being put in place for this meeting.

The manager attended monthly manager meetings the records of which contained no narrative but generated action sheets per centre. A series of audits had also been conducted by the company quality assurance and practice manager and whilst initially in 2018 these were satisfied with the completion of governance tasks within the centre they had latterly, in late 2018 and early 2019, identified areas that required focused attention such as regularisation of supervision timeframes and improvements in records. Inspectors had access to a limited amount of the previous manager's work from prior to their departure due to an issue with lack of access to a laptop. The senior management were arranging repair to the laptop to allow the new manager access to the data contained within it.

The quality assurance audit reports were quarterly and generated action plans for the attention of the manager. There were aspects of the previous two audits outstanding at the time of this inspection visit and the inspectors have recommended that the quality assurance manager and the operations manager review their task division to improve their tracking and actions related to governance. When inspectors reviewed the visitor's book it was clear that there were regular visitors to the centre from senior management as well as external others such as the GAL or the social worker and therefore regular opportunities for records to be sampled by all management. The management have now introduced a management and governance document tracker with a daily and weekly tick box system. Inspectors found that there was a gap in what the operational visits and the QA audits identified, the monthly managers checklists and areas of practice development that should have been noted but the system as constructed did not capture. Inspectors have discussed this with the relevant line management and gave the specific examples of areas related to supervision records, team meetings and handovers.

Inspectors independently found key aspects of records that required attention that had not come under scrutiny such as the outdated content of the daily logs which contained goals such as 'settle into placement' and 'build relationships within the centre', when the young person had lived at the centre sixteen months at that time. The daily log where specific and up to date was of a good standard but was inconsistent in tracking diet, exercise, hygiene, education, and clothing. The daily log must be current, utilise cross referencing well and display a clear line between planning, clinical, medical and therapeutic advice and direction. These were the most difficult aspects for inspectors to track in their document review. There was no

cohesive evidence of a clinically directed health programme and this was and is urgent and crucial for this young person. Inspectors discussed this with the social worker and their team leader and they have agreed to correlate any known specialist medical referrals to establish what was pending and what is required. The company had provided assistance from their own clinical team manager in the interim.

Inspectors did find that there was evidence of staff knowledge and implementation of the model of care in their day to day work and there was consistent feedback to inspectors of the approach being about role modelling, consistency, being caring and providing a structured plan with the wider goal of supporting the development of empathy and self awareness. The staff team was aware of the young person's relative isolation and worked to address this through their planning. The social work team were satisfied with the young person's evidenced progression in specific areas and were alert to the outstanding areas that required co-ordinated ongoing planning and risk management. There were areas of disagreement between the centre and the social work department but these were managed through clear interdisciplinary communication and review.

Additional areas for action found by inspectors were the absence of an up to date health and safety statement for this centre. One was made available after this inspection and the line management stated that a previously updated one had been forwarded to the centre following an action identified by the inspectorate in the May 2018 inspection. This was not available at the centre during the inspection visit; the 2016 version was in use. Inspectors found that the centres registers required focused review to ensure that all relevant matters related to complaints and child protection were fully cross referenced to the file and contain accurate records of outcomes. The manager must also introduce a tracking and review mechanism for the range of restrictive practices in place at the centre, these included but were not limited to a completely empty kitchen, use of plastic cutlery and crockery and single occupancy.

3.2.3 Practices that did not meet the required standard

None identified.

3.2.4 Regulation Based Requirements

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 7, Staffing (Numbers, Experience and Qualifications)

Required Action

- The external management team must review their operational governance and quality assurance systems to better complement each other in delivering appropriate professional governance and oversight processes for the centre.
- The centre manager must ensure that the daily log is current, utilises cross referencing well and display a clear line between planning, clinical, medical and therapeutic advice and direction. These were the
- The external management team alongside the centre manager must ensure that all registers, care files and administrative documents are reviewed and consistently improved for clarity, content and relevance for the care of the young person and operation of the centre.

3.4 Children's Rights

Standard

The rights of the Young People are reflected in all centre policies and care practices. Young People and their parents are informed of their rights by supervising social workers and centre staff.

3.4.1 Practices that met the required standard in full

Consultation

The centre had a policy on consultation with children that inspectors found was implemented in practice. There were house meetings held weekly and the young person was informed of and also involved in planning around their life. Inspectors found that records were maintained of those meetings but not of the outcomes or answers to the requests and the new manager should document these.

The young person told inspectors that they liked the staff team but did not like the house. They said that there were people to talk to if they needed something, were unhappy or just wanted to spend time with someone. They knew about their key workers and what rewards and sanctions they could expect. They were recently involved in doing up their own reward goals for a return to school. They outlined that the team members told them about the daily plan and that they liked knowing what to expect. The main wish that the young person wanted inspectors and others to know about their wish to move house with the team.

The young person was aware of some of the restrictive practices put in place, in consultation with Tusla for their safety, for example the use of plastic cutlery and crockery. They had asked for changes in that through the house meeting and a plan was being put in place, with clinical guidance, to begin this process. The young person was aware of the fact that they would not be followed onto the road by staff as it was found by the company to be too unsafe for everyone and the young person had discussed this with their social worker. The centre and the social work department were aware that the daily quality of life for a young person in single occupancy was a matter for ongoing review. It was named in the child in care reviews that the physical premises were not fit for purpose and was a source of significant concern.

An EPIC advocate had been invited to the centre to meet the young person and the young person's comments about ongoing questions they have related to being in care were recorded by staff. There was evidence of the young person being supported in their preparation for contributing to their child in care review meetings and the chairperson had met with the young person on a number of occasions. Their observations were recorded in the statutory minutes.

Access to information

The centre had a suitable policy in place governing access to information and the young person was informed of their rights through a number of avenues. The young person knew they could ask staff to see their daily log and were happy with that they told inspectors. The new manager had recently purchased two locked cabinets, one for supervision and management records and one for the young person's day to day records.

3.4.2 Practices that met the required standard in some respect only

Complaints

The centre had a policy on complaints that outlined a rights based approach to complaints and listening to young people. The aim of the policy was local resolution as the first goal and if not then external notification to all relevant parties was to be completed.

Inspectors found that there was a register of complaints and complaint records contained on the young person's file. A comment made by the young person regarding use of language by staff did not appear on the informal or formal complaints records and inspectors have asked management to check this in the files. There was evidence that the policy approach of local resolution as the first step was in

operation. In 2019 three complaints were recorded but the records themselves were not well maintained with regard to format, signing and cross referencing. A wider review by inspectors displayed some evidence of follow up or attempted follow up with the young person.

A matter that fit into the child protection category had initially started in the complaints section and was then correctly reassigned but did not then present with the record of the young person's child protection reporting forms and were not contained within the register either under the correct designation. This has also been named to the manager for action and outlined to external management as an item that should have been identified through their governance systems.

Of the three complaint records on file for 2019 the most recent was in June, this was dealt with as an informal internally resolved matter and this related to the absence of live night staff some nights of the week due to the companies difficulty in sourcing same. T here was evidence that the young person was listened to and action taken to address the matter. Inspectors found that the social worker and their team leader were aware of this and of the majority of the complaint issues that the young person had raised and were always kept updated on the live night staffing gaps.

3.4.3 Practices that did not meet the required standard

None identified

3.4.4 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 II, Article 4, Consultation with Young People.***

Required Action

- The centre manager and their external management must review the young person's file to satisfy themselves that all matters related to complaints have been logged and acted upon appropriately
- The centre manager and their external management must review the complaints register to ensure that all records are complete.

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

The centre had a policy statement on safeguarding and child protection – under which the supporting policies and procedures were grouped. The company have been provided with a list of updates and corrections required for the child protection policy suite by the inspection service.

There was evidence of the ongoing recruitment of staff suitable to the posts and personnel files were well organised and completed to a good standard. A number of staff had left and a large number of staff were required to cover the daily three persons and one live night agreed staffing levels. The management had some measures in place to address these issues but inspectors recommend that the manager track for themselves how many persons work at the centre to seek to manage numbers of different personnel where necessary.

The placement had been devised as structured in agreement with Tusla placement team, the referring social work department and the Tusla national clinical team for special care, ACTS, as clinical advisors for the initial phase of the placement. The young person has had a range of visitors at the centre including their social worker and the team leader and the young person's guardian ad litum. An EPIC advocate had been invited to and had come to the centre to talk to the young person. Regular professionals meetings act as a safeguard process around their placement.

The social worker and their team leader outlined that they had seen positives in team cohesion, communication and progression in areas of the young person's life relevant to their identified needs. There was communication with the manager by the social work team around their preferred timeframes for updates and requests for improvements in written communication that the manager was aware of. The social worker had visited the young person regularly and aimed to visit after a crisis where one occurs. They were aware of the young person's views and identified that it is their goal to read the daily logs during one of their future visits to the centre.

The young person had regular access with family members and visits to the centre were facilitated with staff support. The young person's wishes regarding access were known for the child in care reviews and by the social worker and their guardian ad litum.

The centre also had an active risk assessed decision document regarding the public road. Inspectors found that the preventative measures were on a separate document to the risk assessment and required that the two documents be brought together to highlight the preventative and safeguarding measures. The Tusla social work department involved had made an assessment of the level of acceptable risk or not involved in this and stated that this was under active review at professionals meetings.

3.7.2 Practices that met the required standard in some respect only

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 child safeguarding statement, CSS, was not displayed during this inspection visit as inspectors were informed that it was being updated to include the new manager details. The new manager has since sent the CSS to the Tusla child safeguarding statement compliance unit, CSSCU, and will forward the updated statement to the inspection service once approved. Staff stated that a copy of the CSS had been displayed consistently in the past and that they had familiarised themselves with it. The centres child protection and safeguarding policy and procedure suite, dated 2019, required corrections and updates and this has been separately outlined to the relevant senior management.

As noted earlier inspectors found that the manager must review the young person's file to ensure that all records related to child protection were fully completed, on file and accurately identified in the register. The social worker was satisfied that there was good communication with the centre and tracking of events of a high risk or child protection nature. They had stated that they will liaise with the manager to ensure that the records were accurate and up to date.

The team had completed the mandatory elearning in Children First and inspectors found variable evidence during interview and in questionnaires of the knowledge base around the child safeguarding statement and child protection policies and procedures and advised that the manager conduct targeted up skilling of the team in conjunction with the company trainers and senior managers.

3.7.3 Practices that did not meet the required standard

None identified

Required Action

- The centre manager must review all child protection reports made to ensure that the individual records are concluded satisfactorily and that the register is accurate and up to date.
- The centre management and staff must complete a focused review and internal training in the child safeguarding statement and the policy and procedures governing child protection once updated.

3.8 Education

Standard

All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate educational facilities.

3.8.1 Practices that met the required standard in full

The young person had a school placement in an educational setting fully suited to their needs. There was information regarding any specific learning or behavioural difficulties that may apply. Inspectors found good evidence of communication between the centre and the school. The centres multidisciplinary team meeting evidenced discussion and planning about how to bring about a return to school following a difficult patch for the young person. The young person themselves became involved in the return to school planning and had input from the outset setting their immediate and longer term goals reward for attendance. A copy of the young person's school report was on file and the school had contributed to a recent child in care review.

3.8.2 Practices that met the required standard in some respect only

None identified

3.8.3 Practices that did not meet the required standard

None identified

3.9 Health

Standard

The health needs of the young person are assessed and met. They are given information and support to make age appropriate choices in relation to their health.

3.9.1 Practices that met the required standard in full

None identified.

3.9.2 Practices that met the required standard in some respect only

The young person had specific health and medical needs that inspectors did not find co-ordinated evidence of referral for on their files or in the care plan. The full medical history was unclear and a number of clinical professionals and teams had been involved over recent years. The social work department agreed with inspectors that a review of the status of any specialist referrals would be completed and urgent referrals to suitable clinical specialists followed up without delay. The social worker had visited the young person's GP with the manager and had since followed up with the practice in order to move health planning forward.

Inspectors did not observe a through placement cohesive diet and exercise programme on the centre files but latterly found a weekly planner with diet and exercise outlined. The last evidenced direct input inspectors could locate on the file from a dietician was in 2018 and this person recommended homemade meals with lots of variety. The inspectors raise the question of how this can be consistently achieved whilst working with two separated food preparation areas one of which has only a hot plate and a grill to feed a minimum of four people for daily meals. It is essential that the centre explore all available resources for health and welfare open to them in a timely manner.

Records were maintained by the team of any medications administered and there were copies of consents provided for the file. There was evidence in key working and individual work of some guidance being provided by staff on health and development related matters.

3.9.3 Practices that did not meet the required standard

None identified.

3.9.4 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 20, Medical Examinations.***

The centre have met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 10, Health Care (Access to Specialist Health Care Services).***

Required Action

- The social work department must ensure that all actions related to healthcare specialist referral are pursued without further delay.
- The centre manager must ensure that all medical and general health records are co-ordinated and that actions are in place to ensure that overall health and wellbeing is prioritised.

3.10 Premises and Safety

Standard

The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

3.10.1 Practices that met the required standard in full

None identified

3.10.2 Practices that met the required standard in some respect only

Maintenance and repairs

The HSE maintenance department, by agreement with Tusla estates, provided the main maintenance for this premises and they were on call for electrics, plumbing and carpentry. They also deal with specific repairs and upgrades. Records were maintained of the works reported to them and their response times, these were generally quick but were always reactive as there is no decision or plan to structurally restore this premises. They noted ongoing issues with the property including the

septic tank and the well. Inspectors requested that it be confirmed when the most recent water test was done, the last record on file was from 2015.

Safety

When inspectors attended for this announced inspection the health and safety statement onsite was from 2016, the senior management stated that an up to date statement had been forwarded to the centre in 2018 but that this was not available at the time of this 2019 visit. In the weeks following the inspection visit an updated safety statement and risk assessment document was forwarded to inspectors. This was completed by the company's health and safety advisor. Some health and safety risk management systems had been maintained up to date but inspectors found it hard to track hazards and action timeframes in response to deficits that were named by the inspection service in 2018. Inspectors have not been able to establish who holds responsibility for pest control and ask that this be followed up also.

Fire Safety

Inspectors found service contracts in place for the alarm, the equipment and the emergency lighting and detectors. The fire safety plan was displayed in the office and this was up to date regarding where the extinguishers were located, what they were and the procedure to follow in the event of a fire. Inspectors observed fire signage, emergency lighting and detectors to be operational throughout the centre. Inspectors recommend that it be identified where the extinguishers are now locked, this was completed following a fire safety review in 2018 and signed off by a fire safety professional. The manager explained that some fire exits were opened using a master key and others not. It had been directed in 2018 by the inspection service that site specific fire training must be done and this had yet to be actioned at the centre. There were records of drills taking place but not if these practiced utilising different keys or different exits or how long it took to access fire fighting equipment.

3.10.3 Practices that did not meet the required standard

Accommodation

This property which comprises the centre, a gym and additional smaller structures on a rural site was the property of HSE estates and had been made available to Tusla by agreement between the two bodies. Tusla in turn provided access to these physical premises for this private provider to run a registered single occupancy step down programme. The centre was first registered to this private provider on the 23/9/2016.

There were inspections conducted by the registration and inspection service in 2017 and in 2018 inspection with the regulations on accommodation and safety and accommodation, safety and fire safety respectively not met. On this occasion the regulation on accommodation has not been met. It has been confirmed by the inspection service through the HSE and Tusla estates that the capital investment required to the fabric of this premises will not be carried out due to the cost implications. Therefore, the premises cannot be verified to be "kept in good structural repair and decorated to a standard which creates a pleasant ambiance" in accordance with criteria 10.1. The premises cannot either be said to be "adequately lit, heated, ventilated and has suitable facilities for cooking and laundry and all equipment is as domestic in style as possible" in accordance with criteria 10.3.

The cooking preparation was done in a utility room at the opposite end of the main building to the kitchen. This room was due for flooring repair but due to a mistake regarding an order the flooring had not been done. There remains open access to the outside in this room and there was no dishwasher. The centre itself had not acted to put safe and hygienic food storage in place. In the summer of 2018 an inspector had stated that "the utility room that was used for storage and preparation of food was not fit for purpose and the flooring and storage areas needed to be immediately addressed".

Following the inspection in 2018 a list of items for cleaning, repair and redecoration were identified. During this inspection key items from standard ten required in the two preceding inspection reports were not completed: site specific fire training, safe storage of food and improvements to the utility room. Also an up to date health and safety statement was not available at the centre at the time of this announced inspection. Items related to safety and risk assessments were not easy to track and therefore unclear with regard to what the full standard of compliance with the original safety statement was.

Some redecoration with curtains, blinds, carpet and soft furnishings had taken place in 2019. The young person liked the improvements but knew that this did not improve the overall property enough and their one request was to move to a new house with the team.

3.10.4 Regulation Based Requirements

The centre has not met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996, -Part III, Article 8, Accommodation.***

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996,***
-Part III, Article 9, Access Arrangements (Privacy)
-Part III, Article 15, Insurance
-Part III, Article 14, Safety Precautions (Compliance with Health and Safety)
-Part III, Article 13, Fire Precautions.

Required Action

- The Director and senior management team must ensure that they source a fit for purpose property for this service to operate from in a timely manner.
- The centre manager must confirm pest control and water test arrangements for the property.
- The operations manager must oversee implementation of the health and safety statement and complete audits monthly in conjunction with the centre manager.
- The senior management team must ensure that site specific fire safety training is conducted with the team at this location.

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 external management team must review their operational governance and quality assurance systems to better complement each other in delivering appropriate professional governance and oversight processes for the centre.	The external management team will review their operational governance and quality assurance systems to better complement each other in delivering appropriate professional governance and oversight processes for the centre. To be completed by 18th October 2019.	Actions identified from review of governance and quality assurance systems will be implemented and these systems will be reviewed on an annual basis to ensure their effectiveness.
	The centre manager must ensure that the daily log is current, utilises cross referencing well and display a clear line between planning, clinical, medical and therapeutic advice and direction.	All daily logs are current and utilise cross referencing with the placement plan. The daily log and the placement plan have been revised with headings that make it clearer what information is required. In place from September 2nd 2019.	The placement plan will be reviewed at each MDT meeting and the daily log will interlink with the placement plan. This will be continuously monitored by house management.
	The external management team alongside the centre manager must ensure that all registers, care files and administrative documents are reviewed and consistently improved for clarity,	The centre manager and external managers will ensure that all registers, care files and administrative documents are regularly reviewed and improved for clarity, content and relevance. Immediate	Centre management and external management will monitor and evaluate all administrative and care files through the centres internal auditing tools.

	content and relevance for the care of the young person and operation of the centre.	and ongoing.	
3.4	The centre manager and their external management must review the young person's file to satisfy themselves that all matters related to complaints have been logged and acted upon appropriately. The centre manager and their external management must review the complaints register to ensure that all records are complete.	The centre manager and clinical manager who is the designated complaints officer have reviewed all matters related to complaints and are satisfied that all complaints had been acted upon appropriately. Completed July 11th 2019. The centre manager and clinical manager (designated complaints officer) reviewed the complaints register and are satisfied that all records are complete. Completed on July 11th 2019.	All complaints will be monitored by centre management and external management to ensure that they are appropriately recorded and reviewed. The clinical manager will maintain oversight of complaints. All complaints will be monitored by centre management and external management to ensure that they are appropriately recorded and reviewed. The clinical manager will maintain oversight of complaints.
3.7	The centre manager must review all child protection reports made to ensure that the individual records are concluded satisfactorily and that the register is accurate and up to date. The centre management and staff must complete a focused review and internal training in the child safeguarding statement and the policy and	All child protection reports have been reviewed and satisfactorily concluded by the centre manager and the clinical manager (designated liaison person). Completed on the 11th July 2019. The Clinical Manager (designated liaison person) will provide training to centre management and the care team on the child safe guarding statement and	Child protection concerns will be monitored and reviewed by the house manager and reported to the designated liaison person as outlined in the centre's Child Safeguarding Statement. The centre manager will ensure all staff working in the centre are up to date with child protection procedures through the use of team meetings, supervision and

	procedures governing child protection once updated.	procedures governing child protection once approved by TUSLA's CSSCU.	refresher training.
3.9	The social work department must ensure that all actions related to healthcare specialist referral are pursued without delay.	The social worker for the young person responded to this report and confirmed that the young person was on a national waiting list for a specialist clinic in a Children's Hospital. The young person has been on the list since October 2017 and has approximately another 7 months before being offered a service. The social worker will write to the clinic in the next week to request that be prioritised. The social worker is in the process of seeking advice from a Paediatric Dietician. The social worker will also see if the dietician is able to co-work with another professional, such as a physiotherapist. This process is on-going. The Social worker will continue to liaise regularly with the young person's GP regarding their on-going health needs. The social worker is also in contact with the following: previous clinical specialists, community primary care services and school and	The young person is being offered, and is attending, regular appointments for other supporting specialist and medical services. There have been new referrals for additional supports and there is on-going correspondence in relation to services for which there is a waiting list. The social worker continues to co-ordinate medical and healthcare professionals.

		community dental.	
	The centre manager must ensure that all medical and general health records are co-ordinated and that available actions are in place to ensure that overall health and wellbeing is prioritised.	The centre manager has put a system in place to track all medical and general health records ensuring that actions are in place and the health of the young person in being prioritised.	The centre manager in consultation with the social work department will ensure that all medical and health actions are in place and prioritised for the young person.
3.10	The Director and senior management team must ensure that they source a fit for purpose property for this service to operate from in a timely manner.	The CEO of the service is actively seeking appropriate alternative accommodation and will be completed in the nearest possible time frame.	The CEO has agreed to an action plan for an alternative property to be actively sought by the 1st of March 2020.
	The centre manager must confirm pest control and water test arrangements for the property.	The centre manager has contacted the relevant departments for testing to be arranged. Details of which will be forwarded to Inspectors when confirmed. Immediate and ongoing.	There is a contract in place between TUSLA and the Pest control company for regular and routine visits to the centre. The water will be tested as necessary pending the recommendation of TUSLA's H&S department.
	The operations manager must oversee implementation of the health and safety statement and complete audits monthly in conjunction with the centre manager.	The operations manager will ensure that the health and safety statement is implemented and that monthly audits are completed. Immediate and ongoing.	The operations manager will ensure that the health and safety statement is implemented and that monthly audit reports are completed and the appropriate action is taken in a timely manner where

	The external management team must ensure that site specific fire safety training is conducted with the team at this location.	Site specific fire safety training has been scheduled for September 11th 2019.	necessary. The centre manager will ensure that all staff working in the centre will complete their fire safety training. The centre manager will monitor the training plan to ensure all training is carried out as required.