An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 138

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Solis MMC**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Announced Inspection**
Date of inspection:	**14th, 16th and 17th February**
Registration Status:	**Registered with an attached condition from 20th July 2021 to 20th July 2024**
Inspection Team:	**Lorna Wogan** **Sinead Tierney**
Date Report Issued:	**15th July 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 20th July 2018. At the time of this inspection the centre was in its second registration and was in year one of the cycle. The centre was last inspected in April 2021 and the inspectors found that the required actions arising from this inspection were met in full.

Following the centre's application for re-registration in July 2021, it was found that the centre did not have a sufficient number of qualified staff. As such it was the finding of the ACIMS Registration Committee that the centre was not in compliance with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 7 Staffing. The Registration Committee applied the following conditions to the centre's registration under Part VIII, Article 61, (6) (a) (i) of the Child Care Act 1991:

- There must be no further admissions of a young person under 18 to this centre until the staff team comprises a minimum of 50% social care qualified staff and that the number, qualifications, experience and availability of members of the staff of the centre are adequate having regard to the number of children residing in the centre and the nature of their needs.

At the time of inspection, the centre had not yet achieved the minimum of 50% social care qualified staff members in order to come into compliance with condition attached. However, centre management were actively trying to recruit additional social care qualified staff to the team in line with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).

The centre was registered as a multi-occupancy service to accommodate four young people, both girls and boys from age thirteen to seventeen years on admission. The centre provided medium to long term care placements. Their person-centred model of care was described as building therapeutic relationships with young people through the adaptation of 'The Seven Habits of Reclaiming Relationships' (Erik K. Laursen) to enable young people to feel supported, cared for, safe and respected. The centre aimed to provide an individualised programme of care to assist each young person to develop resiliency through the medium of positive and caring relationships. The centre provided young people with the opportunity to develop positive relationships with caring adults who model appropriate ways of dealing with

emotions and life challenges. There were three children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and relevant social work departments on the 23rd March 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 24th March 2022. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deemed the centre to be not continuing to operate in adherence with regulatory frameworks and standards in line with its registration. It was found that the centre did not have sufficient numbers of social care qualified staff. It was the finding of the ACIMS Registration Committee that the centre did not meet the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 7 Staffing. The registration committee wrote to the registered proprietor and proposed to attach a condition to the registration on the 09th May 2022. Subsequent to this, the service submitted evidence that action had been taken to address the issues in relation to staffing and that the centre was now in compliance.

As such, it is the decision of the Child and Family Agency to register this centre, ID Number: 138 without attached conditions from the from the 20th of July 2021 to the 20th of July 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

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

The inspectors found the residential centre was child centred and homely and the environment promoted the safety and wellbeing of each of the young people in placement. The environment was suitable for providing safe and effective care for the number of young people in placement and was designed to meet their specific needs. The centre layout and design provided spaces for recreation and activities, spacious communal areas for mealtimes and relaxation, space for privacy and rest and all areas of the house were well maintained and decorated to a high standard. There were set cleaning schedules in place to ensure good standards of hygiene. The inspectors were satisfied there were adequate arrangements in place for young people to have visits from family members and social workers that were private. This assessment of the premises was endorsed by the children, parents, Guardian ad Litems and social workers who were interviewed by the inspectors.

There were sufficient bathroom and laundry facilities for the young people. Each young person had their own bedroom with sufficient storage space where they could secure personal items. The centre was adequately lit, heated, and ventilated. There were suitable facilities for cooking and laundry. There were lots of personal touches within the house and the young people confirmed they were consulted and had opportunities to be involved in buying items for the house. The inspectors saw this reflected in house meeting records. There was a culture of regard and respect for the living space that was supported by the managers and staff team and this in turn encouraged the young people to invest in their living environment. A review of the maintenance log evidenced that maintenance issues were dealt with in a prompt manner and there were no open maintenance issues at the time of the inspection. The maintenance, safety and upkeep of the house was reflected across the centre records, in management audits and team meeting records.

As part of the re-registration process in July 2021 the proprietor provided evidence that the centre was adequately insured against accidents and injury. There were adequate arrangements in place for the reporting and recording of accidents and injuries affecting the young people. The centre maintained an accident register and accidents were found to be appropriately reported and recorded. There was a clear procedure in place to submit accident reports to the services head office and accidents reports were also maintained on the individual Care Records. There were adequate arrangements in place to guard against the risk of injury occurring on and around the premises particularly in relation to the storage of medicines, cleaning, and other materials.

Written confirmation was furnished to the inspectorate from a suitably qualified architect with regard to the centre's compliance with the Building Regulations Part B - Fire Safety. The centre maintained a fire safety register and the centre manager was the appointed fire safety representative. The fire safety statement and the fire evacuation plan were displayed in the staff office. There was adequate means of escape including emergency lighting and there was a suitable procedure for the safe evacuation of young people and staff. Exit routes were marked, sufficient and unencumbered. The fire assembly point was clearly identified. Fire extinguishers and the required fire-fighting equipment were located at identified fire points and were serviced annually. There was evidence that detection equipment and fire safety equipment was maintained as required. A staff member demonstrated the daily fire checks in a competent manner during the inspection. The frequency of all fire safety checks was clearly set out on the fire register. Fire drills were undertaken and recorded. The staff and young people interviewed by the inspectors confirmed they participated in fire drills and fire safety training. Staff undertook training in fire prevention and evacuation in July 2021 and while verification of staff training was not available to the inspectors when on site, verification of this training was subsequently forwarded to the inspectors by the centre manager. Staff personnel files reviewed by the inspectors verified that staff signed the centres fire safety and health and safety statements to verify they had read and understood their responsibilities in this regard.

The centre had a written health and safety policy. A safety statement was displayed in the centre that identified the health and safety representative and broadly outlined the aims of the company in relation to health and safety. However, the inspectors found the safety statement was not developed in line with the requirements of the Health, Safety and Welfare at Work Act, 2005. The health and safety statement was not site specific as required, and it was not dated or signed to evidence it was reviewed, at least annually, by the centre manager/health and safety representative.

The inspectors found a wide range of centre-specific safety risks assessments that appropriately identified and assessed the risks with robust control measures in place however, these assessments were not identified in the centre's safety statement or evidenced as reviewed as part of a required review of the safety statement. The safety statement must show hazards have been identified and risks assessed, eliminated, controlled, and reviewed. The service manager in conjunction with the centre manager must review the requirements of the Health, Safety and Welfare at Work Act, 2005 and ensure the centre's safety statement is fully aligned to the requirements of the Health, Safety and Welfare at Work Act, 2005.

A monthly on-site health and safety check was completed by staff and was subject to oversight by internal and external managers. Health and safety matters were discussed at team meetings, management meetings and in the daily handovers. Recommendations from audits in relation to the fire safety were promptly actioned by the centre manager. Health and safety training was provided to staff on a roll over basis.

First aid kits were located in the centre and in centre vehicles. There was evidence of a roll over training schedule for staff that included basic first aid training. However, there were no staff trained in First Aid Response (FAR) which is the recognised training standard for occupational first aid in workplaces. The legislation requires that workplaces undertake a risk assessment as part of the safety statement regarding the degree of hazards, the level of accidents that occur, the nature of the work and the size and location of the workplace to determine how many First Aid Response (FAR) qualified staff they require. The names of trained first aiders must also be included on the centre safety statement.

The centre had written policies on the safe administration of medication. Staff were facilitated to attend training in the safe administration of medication. Records for the administration of medications were maintained. The centre had a system in place to monitor medication stocks. There were systems in place to monitor supplies in the first aid kit. Medication was safely stored in a locked medicine cabinet.

The centre had systems in place to ensure centre vehicles were road worthy. Records of car maintenance checks were held in the centre. The vehicles used to transport the young people were regularly serviced, subject to NCT as required and had valid tax and insurance. All staff were legally licensed and insured to drive the centre vehicles and a copy of driving licences were stored on the personnel files reviewed by the inspectors.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **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 2.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The service manager in conjunction with the centre manager must review the requirements of the Health, Safety and Welfare at Work Act, 2005 and ensure the centre's safety statement is fully aligned to the requirements of this workplace legislation. The centre's safety statement must be reviewed annually and amended where required.
- The service manager in conjunction with the centre manager must undertake a risk assessment as part of the safety statement to determine how many First Aid Response (FAR) qualified staff they require. The names of trained first aiders must be included on the centre safety statement.

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

Theme 3: Safe Care and Support

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

There were policies and procedures in place to guide staff in the management of behaviour. The policies outlined how staff promoted positive behaviour with a focus on children's rights, participation of the young people in their care, positive reinforcement and rewarding achievements. We found that staff were provided with relevant training in 2021 to ensure they were competent to implement the care

approaches. Staff had access to specialist advice and support in relation to trauma and attachment informed approaches and were facilitated to attend training in youth mental health first aid. There was evidence that the approach to promoting positive behaviour was led by the centre manager and the deputy manager. Learning and reflection on care approaches was evident in team meeting records, staff supervision, end of shift analysis and debriefings following incidents. Supervision records were of a high standard in relation to teaching, supporting, and reflecting with staff on their approach to promoting positive behaviour.

Parents and external professionals interviewed by the inspectors confirmed that staff were attuned to the young people's behavioural presentation and recognised when they required additional guidance and support. The young people themselves stated that staff supported them in a positive manner. There was evidence that staff communicated with the young people in a clear, appropriate, and positive manner following significant events, and through key working and individual work sessions. Discussions in key working and house meetings centred around values of respect, creating a positive environment for all, 'walking in someone else's shoes'. Inspectors found that staff responded in a prompt and supportive manner when an issue of bullying arose in the centre. This issue was managed in line with the behaviour management and anti-bullying policy and was addressed with the young people individually and then collectively at a house meeting that included a review of the centre's anti-bullying policy. The young person concerned, and their parent informed the inspectors they were satisfied that the issue was well managed and was satisfactorily resolved.

The young people were aware of expectations in relation to their behaviour and the consequences for unacceptable behaviour. They told the inspector that consequences were reasonable and fair. Consequences were found to be linked to the misdemeanor and there was a learning aspect to them. There was a strong focus on restorative practices to help build and maintain positive healthy relationships and this was evidenced in staff interactions and approaches. Consequences were recorded on a register for monitoring, tracking and oversight by managers.

Risks in relation to behavioural presentation were identified with the young people, their families and social workers on referral and admission and were subject to structured risk assessments. Each young person had a placement support plan that was comprehensive and up to date. The support plans outlined routine plans for each young person, behaviour management plans to address specific identified behavioural presentations and staff interventions, they also contained the individual crisis management plans and absence management plans. The staff were trained in a

research-based behaviour management system. The inspectors found that physical restraint intervention was not required to manage behaviour within the current resident group. Staff were appropriately trained in the centre's behaviour management system and had received the required refresher training. Training records were maintained in the centre however there was no evidence of staff certification in relation to this training as required. The service manager must ensure that certification of staff training in the behaviour management system is maintained on file.

There was evidence of regular auditing and monitoring of the residential centres approach to managing behaviours that challenge through structured audits undertaken by the centre manager, the service manager, and the external auditor. Action plans were developed following audits and recommendations were implemented in a timely manner. There was evidence of good analysis of the approach to the management of behaviour by managers at all levels. Significant events were reviewed at regional managers meetings and identified learning outcomes were relayed to the team.

The centre had a written procedure on the use of restrictive practices. There was a system in place for documenting restrictive practices however, the inspectors found the recording system was not adequate for its purpose and the recording of the daily implementation of such practices was unnecessary. Also, the inspectors found that the system in place of de-classifying a restrictive practice once there was consultation and agreement to implement the practice with a social worker/parent was incorrect. The restrictive practice continues to be a restrictive practice even when agreed in consultation with relevant parties. The inspectors recommend that the register template is revised to include the name of the young person, the date of implementation of the restrictive practice, a record of the identified restrictive practice, the date of consultation with the social worker/parent and the date of review of the practice. The inspectors also recommend a review of the guidance in relation to restrictive practices is undertaken to provide further clarity for staff in relation to identifying and recording of restrictive practices and to also include the procedure for consultation with social workers and parents in relation to such practices.

Compliance with regulations	
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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The service manager must ensure that certification of staff training in the behaviour management system is maintained on file.
- The centre manager must review the current systems in place for recording restrictive practices to ensure the records contain all the required information in relation to the use of restrictive practice to facilitate robust tracking, oversight and review of such practices.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The inspectors found that leadership was demonstrated at all levels in the centre and within the wider organisation. There were clearly defined governance arrangements and structures that set out lines of accountability, roles, and responsibilities. Staff were provided with a job description and roles at all levels were set out in detail in the centre's policy document. Staff interviewed were aware and knowledgeable in relation to their roles and staff were provided with robust induction into the service and into their specific role, that continued throughout their probationary period.

There were specific induction training days facilitated by managers for the social care leaders within the centre.

The centre manager was the appointed person in charge who had overall accountability and responsibility for the delivery of the service. The centre manager was appropriately qualified and experienced to undertake the role. There was an internal management structure appropriate to the size and purpose and function of the centre which comprised of the centre manager and the deputy manager, who were based at the centre Monday to Friday. There was evidence that centre manager and the deputy manager worked collaboratively and had clearly defined leadership and oversight responsibilities. Additionally, there were three social care leaders who worked alongside a team of 5.6 social care staff and provided guidance, direction, and support to them in their work. The full complement of core staff as outlined in the centre's statement of purpose was 11 social care staff and the service manager must submit a plan detailing how and when compliance with the staffing numbers as set out in their statement of purpose and the regulatory requirement to have 50% of the team with the appropriate social care qualification will be achieved.

There were clear and robust systems in place to assess the centre's compliance with regulations, national standards, best practice and to ensure they were operating in line with their policies and procedures. Audits were undertaken by the social care leaders, the centre manager, the service manager, and the external quality assurance officer. Audits reviewed by the inspectors were found to be comprehensive with an evident focus on quality of practice as well as on the administrative systems. Audit reports and service managers reports were completed in a timely manner with clear actions identified and responsive timeframes on the required actions. There were a range of internal and external management meetings that evidenced good governance and oversight of practices and service operations.

The centre was contracted to provide the service by Tusla's National Private Placement Team (NPPT) and the proprietor, and the service manager met annually with the NPPT to review the services provided and the children's progress.

All operational policies and procedures for the centre were developed and updated by the quality assurance officer and the senior management team. The deputy manager undertook policy training supervision with new staff members during their probation. Staff confirmed that new and updated policies were reviewed in supervision, at team meetings and reviewed following specific practice issues that arose in the centre.

There was a risk management framework in place. The inspectors found robust systems were in place for the identification and management of risk. There was evidence of appropriate and defined control measures to reduce and manage risks in the centre. Risk and the management of risk was discussed in many forums and internal and external managers had systems in place for oversight of risks in the centre. The centre had systems in place to identify and record site-specific risk assessments, corporate risks, Covid-19 risks, and environmental risks. Risks associated with the individual young people were set out in their individual placement support plans. However, the inspectors found some anomalies in the system for measuring risk on the matrix system. All identified risks in the centre were initially assigned the maximum matrix score of 25. Subsequently, the centre manager re-assessed the likelihood of the risk occurring and the impact of the risk when mitigation measures were in place and that resulted in a lower residual score. However, the risk assessments reviewed by the inspectors found that the residual scores continued to remain at a medium to high level despite the mitigation measures in place and the reduced likelihood of the risk occurring. The centre manager must review the application of the risk matrix scoring system when initially considering risks to ensure the residual score is proportionate to the likelihood and impact of the risk occurring.

There were alternative management arrangements in place for when the centre manager was on leave. The centre had a standard operating procedure that was detailed and set out management duties. The deputy manager was delegated responsibility to undertake some or all the centre managers duties when they were on leave and a written record was kept of the duties delegated to the deputy manager and key decisions made in relation to the delegation of management duties. This record of delegated tasks was evident in the deputy managers supervision records.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The service manager must submit a plan detailing how and when compliance with the staffing numbers as set out in their statement of purpose and the regulatory requirement to have 50% of the team with the appropriate social care qualification will be achieved.
- The centre manager must review the application of the risk matrix scoring system when initially considering risks to ensure the residual score is proportionate to the impact and likelihood of the risk occurring.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The service manager in conjunction with the centre manager must review the requirements of the Health, Safety and Welfare at Work Act, 2005 and ensure the centre's safety statement is fully aligned to the requirements of this workplace legislation. The centre's safety statement must be reviewed annually and amended where required.	Service Manager and Centre Manager will review the centre's safety statement and ensure that same is aligned to the Health, Safety and Welfare at Work 2005. Quality Assurance are currently reviewing the document in line the Acts requirements. Once this achieved, the centre will ensure it is unique to the centre. Time frame: 6th March will be finalised at Operational Management Meeting.	Centre Manager will ensure that the centre's Safety Statement is reviewed annually and updated to reflect any changes on workplace legislation.
	The service manager in conjunction with the centre manager must undertake a risk assessment as part of the safety statement to determine how many First Aid Response (FAR) qualified staff they require. The names of trained first aiders must be included on the centre safety statement.	Service Manager and Centre Manager to undertake a risk assessment, as per Safety Statement to determine how many staff require the First Aid Response (FAR) qualification. Time frame: 2 x SCLs to receive First Aid Response training on 4th and 8th April 2022. An additional date for FAR is to be secured for	Centre Manager will ensure that the required ratio of qualified FAR staff for the centre is maintained.

		the third SCL. Community First Aid Responder training is being secured for all other social care staff. The centre's safety statement will be updated accordingly to reflect the names of the qualified First Aid Responders.	
3	The service manager must ensure that certification of staff training in the behaviour management system is maintained on file. The centre manager must review the current systems in place for recording restrictive practices to ensure the records contain all the required information in relation to the use of restrictive practice to facilitate robust tracking, oversight and review of such practices.	Centre Manager will oversee the setup of a specific training folder that will include all staff's training records and associated certificates. This will remain on site going forwards. Timeframe: 1st April 2022. Centre Manager will request an immediate review in consultation with Service Manager and Quality Auditor on refining the centre's current restrictive practice processes to ensure a robust tracking, oversight and review of restrictive register and practices. Reviewed and issued by Quality Auditor on the 25th March 2022.	Centre Manager will ensure that all staff training records and certificates are updated and filed within the specific training folder. Implement all guidance from Service Manager and Quality Auditor.

5	The service manager must submit a plan detailing how and when compliance with the staffing numbers as set out in their statement of purpose and the regulatory requirement to have 50% of the team with the appropriate social care qualification will be achieved.	Service Management have driven recruitment for the region continually with advertisements online and in the local press / colleges in order to attempt to meet the required 50% quota. This has proven to be extremely challenging as applications to us with the social care qualification have become less frequent; there have been various barriers to this such as the impact of Covid on students completing placements. We are very aware of the need to meet this 50% quota and will fill this remaining place when the first opportunity arises. For this reason, it is impossible to assert a direct timeframe on this being met, however, we are conscious that this needs to happen as soon as possible and we aim to have this resolved within two months to enable lifting of restrictions currently placed upon the Centre.	This has been an ongoing issue as the 50% contingent is challenging. Our recruitment process has highlighted social care as the preferred qualification and we will endeavour to push this recruitment drive continually.
	The centre manager must review the application of the risk matrix scoring system when initially considering risks to ensure the residual score is	Deputy and Centre Manager embraced preliminary feedback on the 17th February 2022 and reviewed the completed risk assessments that were on file for the young people. Updated risk assessments now	Going forward, Centre Manager and Deputy Manager will ensure appropriate analysis of the risks and will give sufficient weighting to the initial risk assessment scoring on the matrix, i.e., not defaulting to

	proportionate to the impact and likelihood of the risk occurring.	ensure that the residual score is proportionate to the impact and likelihood of the risk occurring. Action completed.	an initial scoring of 25.