An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 149

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**24Hr Care Services Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**21st & 22nd April 2021**
Registration Status:	**Registered from the 14th of March 2019 to the 14th of March 2022**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**28th July 2021**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 14th of March 2019. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from 14th of March 2019 to the 14th of March 2022.

The centre was registered to provide medium to long term care for up to four young people aged thirteen to seventeen upon admission. The centres stated aims were to promote positive outcomes through education and building good family contact. The statement of purpose and function stated that they would build trusting and co-operative relationships with young people and identify their strengths and resilience's. There were four young people on the register of young people at the time of the announcement of the inspection with three in residence during the dates of the visit.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child Centred Care and Support	1.6
2: Effective Care and Support	2.1, 2.2, 2.3, 2.4, 2.5
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.4

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 22nd of June 2021 and to the relevant social work departments on the 22nd of June 2021. 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 and a meeting with the directors was used to inform the registration decision. The centre manager returned the report with a CAPA on the 5th of July 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed. The regulatory non-compliance was deemed to have been addressed at this time.

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: without attached conditions from the 14th of March 2019 to 14th of March 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 7: Staffing
Regulation 9: Access Arrangements
Regulation 11: Religion
Regulation 12: Provision of Food and Cooking Facilities
Regulation 16: Notification of Significant Events

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.

Inspectors found that the centre had a number of mechanisms in place intended to support the young people to be heard within the centre, these were evidenced through the young people's weekly meetings and the one to one work with their key worker. The staff in their questionnaire's gave a positive commitment to young people's meetings and their goal of gaining young people's input. However, inspectors did not find that the practices at the centre had supported a children's rights based focus that was fully realised in practice as yet. There was a focus on sanctions and rules with less recorded evidence of the implementation of a positive learning focus.

The centre had a policy on complaints, the policy provided procedures on internal and external/formal complaints. The complaints policy structure should be improved to highlight the procedures including what constitutes the different categories of complaints and to clarify how the governance and safeguarding of the complaints process will be addressed by the company. The parent's booklet did not contain information on a parent complaints procedure and must include this information. There was evidence that parents were aware of complaints made by their child and on occasion had been actively involved in the resolution process.

Inspectors found that the staff team were uncertain regarding complaints procedures, with aspects of previous complaint outcomes not being known and found that the team members had limited experience as yet in implementing the policy in practice. Staff were also unclear about what process should or would follow once a complaint was notified externally.

The centre had a register for formal complaints and for informal complaints, inspectors recommend the centre review their terminology to clearly identify the categories as internal and external or notifiable and non-notifiable. There was no one reliable mechanism found for informing social workers of all internal complaints. The social workers confirmed through interview with inspectors that they did have knowledge of the items found on the registers overall and none had outstanding or open complaints prior to the commencement of this inspection process. The social workers had been satisfied that all complaints had been closed.

The register of formal complaints had no entries since 2019 and two in total since the centre opened in that year. Inspectors found that the register for internally managed complaints required improvement to note who reported it, if a young person was satisfied with the outcome, who responded and if any escalation to external complaint was required. The centre manager had full records of some internal complaints through to outcomes but not all consistently. A staff member had been assigned to oversee the registers and there was a dedicated section on the team minutes recently added to have discussion and follow up on all types of complaints.

As part of the information gathering for this inspection a young person who was still on the register of young people but not residing at the house for a number of weeks made a range of complaints and comments about their experience at the centre, they did so in writing to inspectors. This was verified on interview with the young person. Inspectors acted to report these to their social worker, the company and by inspection through the relevant Tusla reporting mechanisms. The social worker commenced an investigation and the centres external management team completed their own investigation of the complaints falling under their remit. The centres external management shared the outcome of their initial findings, completed in a timely manner, with the alternative care inspection and monitoring regional management. Whilst concluding that the majority of the complaints were unfounded they did identify that additional training was necessary in the staff code of conduct, professional communication skills, safeguarding and complaints.

The team meeting minutes and the senior management team meeting minutes did have the headings on complaints and child protection reporting but the minutes did not reflect review processes, learning, young person's view of outcomes or any further changes required. Therefore, the minutes did not fully reflect and record the centres stated commitment to transparency and learning.

There were schedules of auditing taking place and reporting from the centre to the service manager and director of care. The senior management team had been at the centre regularly and stated that they had provided opportunities for young people to get responses to issues and to raise complaints directly to them. They reported that this was through regular physical presence both announced and unannounced and one to one time with young people, they stated that they had received no additional complaints. Inspectors found that there must be reflection and review by the management and the team on the information gathered during this inspection process to inform their future practice in facilitating the voice of young people and management of complaints.

The recurring themes, from a variety of young people, on internal complaints related to communication and mutual respect. Complaints included food - the source and variety; peer behaviour, rodent activity and use of or access to a personal mobile phone. The governance of complaints did not evidence the problem solving implemented in response to these matters, inspectors heard about aspects of them from a variety of avenues and saw it recorded on a young person's file in relation to food options for example. The centres complaints policy stated its purpose as promoting openness and transparency by welcoming feedback to inform service improvement and this was not evident and must be improved upon to foster better governance, oversight and safety for young people.

Compliance with Regulations	
Regulation met	**The listed regulations not examined**
Regulation not met	**The listed regulations not examined**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 1.6 only examined**

Actions required

- The registered proprietor must ensure that the systems and model in place at the centre takes account of a children's rights and consultation based focus in order to inform practice development.
- The registered proprietor, their senior management team and the centre management must ensure that the policy on complaints is reviewed with the

procedures and categories clarified. The staff team must be trained in the revised policy on complaints.

- The centre manager must review their recording of all types of complaints and establish the means through which social workers are made aware of the different types of complaints and concerns.
- The centre management must review the registers in place to record and track all types of complaints in line with the policy and procedures.
- The registered proprietor must ensure that auditing addresses root causes of all types of complaints and the quality of the processes they have in place to address complaints.

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

The centre had a policy on admissions developed in line with the National Standards for Children's Residential Centres HIQA (2018) and had a senior team admissions and discharge group in place to review all referrals to the centre. The most recent young person who moved into the centre went through a period of transition and introduction to the team and centre. The team were evidenced as preparing for the young person's admission to the centre through their team meeting. Transitions were individualised and tailored in line with the needs of a young person as part of the needs assessment process.

The centre had a young person's booklet, which was detailed as provided to the young person prior to admission. A key worker was assigned and supported the transition and thereafter completed the follow up provision of information in the first weeks after admission. The content of the booklet was expressed in a manner that moved between child friendly and more formal language and would benefit from review and input from young people to make it more cohesive and uniformly child friendly. The

booklet described the centre as short to medium term when it is in fact medium to long term.

In accordance with their policy the centre management had completed a pre admission risk assessment and a consultation process, this took account of the group mix. The social workers confirmed through interview that this took place. The social worker for the most recent admission said that they found the centre consistent in noting in advance the areas of peer difficulties that did arise and had sought to address these.

A copy of the most recent pre admission 'risk assessment and management of risk' document was reviewed and it was found to be a structured format with a matrix for risk measurement. The top and most critical score on this matrix was met on sixteen out of twenty-eight categories on this document for a recent admission, this did not appear to be in the first instance coherent with their admission policy and secondly with the young person's actual profile and potential fit within the centre. The young person has been settling well into the centre.

The pre admission risk assessment document did outline the policies, staffing and structure they could offer but did not address how these would mitigate the risks and this score was not obvious to the inspector on the document. The team must review this document, the use of scoring, its purpose and role in the through placement risk and safety planning. Some of the strengths in the service like the inter-disciplinary consultation and the availability of a counselling psychologist for advice were not noted clearly in the general admissions procedures.

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

There was evidence in key working and individual work of the staff team preparing young people for their child in care review meetings. Where a young person may have not attended the staff team brought them feedback regarding the decisions made. There were well maintained records on file of contact with families and social workers in preparation for care plan meetings. The young people at the centre had care plans on file that were completed within the regulatory timeframes and where required the centre manager had followed up to ensure that child in care reviews were called promptly.

The placement plans, called placement support plans, for the young people were structured to be an update as well as a plan and were shared with the social workers involved on a fortnightly basis. The plans therefore read as more representative of a progress report as opposed to the forward plan.

Inspectors found that the placement plans were shared with professionals, families and young people were consulted, many of the core goals were reflected on the plans. There were aspects of some young peoples referred needs and vulnerabilities not robustly evidenced on the plans, for example concerns regarding a recent history of suspected child exploitation. The individual placement goals were often assigned to the team as opposed to a specific person and would benefit from being more specific regarding actions required to meet the goals. The centre had established a system of key working case management but no records were available at the time of the inspection to review of that process. There was evidence of progress for the two young people who had lived in the centre medium term and progress had been noted for a third young person before a decline in the placement prior to them leaving the care of the centre.

Inspectors discussed with the centre management that the education goals of some young people, in line with their care plan and placement plan, were potentially impacted during the pandemic due to the centres lack of additional digital devices to support online access to education during the pandemic. Inspectors were told by the management that the centre did not purchase additional digital devices during the pandemic and requested that the referring social work areas resource same. It was reported to inspectors by staff that education was, for example, completed through a mobile phone screen and an education provider for a young person reported significant connection issues related to internet access in the centre. A social worker had resourced a laptop through an external public service to donate to a young person.

The centres directors stated that it was not their role to put such additional resources in place and that this was the responsibility of Tusla as the placing agency. The centre did have one laptop for young people, it was shared between three and at certain points four young people, staff reported that it had on occasion been broken. Inspectors found that in this area of placement plan support that the centre did not respond in a timely manner to robustly satisfy themselves that young people's educational needs were supported.

The young people's files contained records of individual work, with some good linking of the individual work to the placement plan goals. The centre management ensured that there was follow up on sourcing a copy of the care plans and child in care review records for each young person's file, this was recorded on each young person's file.

There was positive feedback from three of the four social workers who responded to this inspection around the centres advocating for and support of therapeutic and clinical services that the young people required. There was evidence of inter disciplinary and multi-disciplinary co-operation in areas of identified need for young people. There were a range of significant complex needs and involvement of professionals to stay up to date with and the team had worked hard to maintain clear information on file and to share this within the team in support of young people. The inspectors found that the centres minutes of team meetings were not of a good standard and did not reflect the quality of discussion and actions agreed and reviewed. The centre staff must work to ensure that the records of key mechanisms like a team meeting are professionally maintained and actions recorded that support the safe care and support for young people.

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

The centre was based in a suitable domestic style house in its own grounds, the house was located adjacent to a village and within easy reach of several large towns. There were bedrooms for each of the young people and adequate private bathroom facilities for them to use. Their rooms could be locked from the inside to ensure privacy and security for their belongings. There was evidence of decoration of bedrooms being discussed and agreed with young people, in some instances this was represented on documents as linked to expected behaviours that were laid out by the centre with regard to respect for the property. Inspectors recommended that this be reviewed as a practice to ensure that this takes place from a positive perspective.

The centre had two sitting rooms, a large kitchen and outside there was a play area and the manager stated that resources of art, entertainment and activities were funded upon request. The centre was painted and decorated in a homely style, there were pictures displayed. There had been a complaint from a young person about rodent activity in their bedroom and this was addressed by the centre and the director of services who also oversees properties and maintenance. The company managed pest control through their own maintenance system and the inspectors require that they evidence a planned yearly approach to pest control at the centre.

The organisation had provided evidence of compliance with fire safety and building control regulations at registration. They provided evidence that the safety statement had been updated for the new manager and that the insurance renewal had taken place in line with regulations. There were records of maintenance and health and safety procedures including hygiene and infection control measures. The centre had responded to the Covid-19 pandemic by acting in accordance with public health guidance.

A young person had raised concerns about their access to medical treatment following a fall and the centre was able to respond to this by the records maintained there in response to the incident. The centre manager evidenced that the accident was recorded, medical advice sought and treatment offered. There were records of accidents maintained at the centre. The centre managed a range of controlled medications daily and there were a number of medication errors and also a small amount of medication missing from the over the counter medication. The medication errors had been reported as significant event notifications and the missing over the counter medication had been investigated, although without resolution and systems improved around the safe management of medication. The team had some training in medication management and had implemented revised procedures for administration, storage and recording of medication. These were being overseen by internal and external management and additional training must be provided where required.

The centre had vehicles for use at the centre with suitable checks in place. There was training for staff in safe driving and car maintenance. There were fire safety records maintained up to date and in accordance with the fire safety statement and procedures. There were contracts in place for fire equipment, the alarm and the emergency lighting and detectors. Inspectors found that the fire safety equipment was in the dedicated locations as outlined on the fire safety and evacuation map.

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

The staff team had established a structured file system for young people. The care records were maintained in accordance with the structure and overseen by key workers in the first instance. The deputy manager and the centre manager audited the files thereafter internally with external audit completed by the service manager on an ongoing basis. The external oversight included spot checks as well as planned

audits and the senior service manager and the director were both happy with the development of the files to best support planning and care at the centre.

Inspectors found that the staff team put significant work into maintaining the files and updating them, the file structure featured an amount of duplication and this could be reviewed to support efficiencies in time management for staff. The centres registers referenced elsewhere in this report were not of the same standard as the care files and required review, for example the register of young people should be enhanced to include family details and kept in a hardback folder or similar to ensure it can be archived and maintained securely for the future.

There was a significant amount of confidential referral material on the files, one in particular and inspectors recommended that this be maintained more securely in order to uphold confidentiality and safe management of information. There was also sensitive images and explicit material maintained on some files and these must be secured to ensure safety, the centre should consult with Gardaí and/or the social work departments if these images relate to open child protection reports to determine who should hold the material.

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

The centre manager and their team were reported by the social workers as having established regular means of communication and response. In some instances, additional placement meetings had been initiated to work collaboratively to address issues arising in the placement. There was feedback to inspectors that where differences arose that these were addressed and agreed upon. A significant event review meeting had been held with a social work department for one young person that was of a good standard and highlighted the value of that process.

There were records maintained on file of contact with families and working with family members towards reunification plans. Inspectors were provided with a parent's leaflet but this did not contain details of a complaints procedure for parents, feedback from one family, inclusive of complaints, had been relayed instead through the inspectorate. The company and centre management must establish a structured system for gaining feedback post placement from families and professionals where ever possible.

There had been two unplanned placement endings, not in line with the care and placement plans, since the last inspection. One was during this inspection process although the young person had not been resident at the centre for a number of weeks prior. The centre did not have a formal evidenced process of placement review in order to inform future placement admissions and care practices but did complete an end of placement report regarding a previous young person. It was reported that a resident young person had given feedback on the impact of admissions and placements but inspectors did not have an opportunity to see evidence of this reviewed at senior level although it was said to have informed the most recent admission to the centre. Feedback had not been sought from the first discharge and it was reported that this would have been difficult whilst acknowledging that no such formal protocol existed. The management stated that they would be interested in implementing this type of feedback structure for the future.

Compliance with Regulation	
Regulation met	**Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
Regulation not met	**Regulation 5**

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

Actions required

- The centre manager must ensure that the young people's booklet is reviewed to ensure it is child friendly, cohesive and accurate.
- The centre manager must review, with the team, the risk assessment and management of risk document, the use of scoring, its purpose and role in the through placement risk and safety planning.
- The centre manager must ensure that the goals in the placement plan reflect the referred needs of the young people.

- The centre staff team must ensure that the key work goals are assigned where possible to named persons in the first instance and then tracked through the intended case management process.
- The centre staff must work to ensure that the records of key mechanisms like a team meeting are professionally maintained and actions reviewed to support safe care and support for young people.
- The registered proprietor must satisfy themselves that all reasonable efforts have been made to resource the placements in order to meet the placement plan goals.
- The maintenance team must implement a structured approach to pest control measures at the centre. The centre manager must thereafter satisfy themselves that these measures are adequate for the property.
- The centre manager must review the files and secure in a safe manner all pre admission confidential information.
- The centre manager must secure or remove sensitive materiel gathered as evidence and seek advice from Gardaí and the social work departments in doing so.
- The senior management team must develop a system of information gathering from young people, families and relevant professionals once placements have ended in order to inform the ongoing development of the centre.

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 centre had policies and procedures in place for child protection and safeguarding that had been updated in February 2021. The start of the document outlines its reference points as being the Children First Act 2011: National Guidance for the Protection and Welfare of Children but the policy proceeded accurately after that point and referred to the appropriate Act and guidance, those being - The Children First Act 2015 and the Child First: National Guidance for the Protection and Welfare of Children 2017. The older reference point should be removed to avoid any confusion.

The centre had a suite of relevant and related child protection procedures combined to create a reference point for procedures related to reporting, to identifying

categories of abuse and the role of the designated liaison person, DLP, and deputy designated liaison person. There was an anti-bullying policy in place that was known by staff. The staff team were knowledgeable about their responsibilities as staff members and regarding whether they were mandated or non-mandated persons. The centres policies did not in fact address mandated persons versus non mandated persons and does not address procedures for the recording of information that did not meet the threshold for reporting. The latter was addressed with regard to external management but not with regard to how it should be managed within a centre and its records.

There were records of child protection reports made through the Tusla portal on relevant young people's files. The records were stored with follow up attached and those that had been concluded by the social work departments contained a letter on file evidencing that. The centre included child protection reporting on their significant event register, inspectors recommended that they establish a standalone child protection and welfare reporting register that would support clear tracking of dates, numbers and responses.

There was a child safeguarding statement in place and this had been deemed compliant with the regulatory requirements by the Tusla child safeguarding statement compliance unit. The statement had been updated to include the new manager and was displayed in the staff office. The staff were familiar with the purpose of the statement and commitments made in the statement were generally realised through policy and practice at the centre. In the area of internet safety and online abuse the centre committed to a specific education programme and inspectors recommended that this be more evidenced in practice or augmented by additional tools should it not meet the needs of the individual young people.

The staff team demonstrated understanding of their child protection responsibilities and need to focus now on development of safeguarding and responding to areas of vulnerability. One significant aspect of a young person's referral risks was largely absent from plans aside from oversight of phone and internet use. The latter was well done and displayed attention to the young person's overall safety but the supporting plans did not expand on the additional means through which the child protection issues would be addressed.

There was a policy on protected disclosures and staff had knowledge of its content and its purpose. The staff had trained in the online Children First eLearning module and had completed internal training in child protection.

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

The centre staff and organisational management described itself as moving toward a therapeutic, trauma informed model of care during 2021. This will have an influence on the system of behaviour management currently in place at the centre and the policies related to behaviour management should be updated along with the statement of purpose and function once completed. Inspectors found that the predominant model of behaviour management was through a type of token economy system at the centre, it involved most areas of pocket money and chore money available to young people. This approach should be reviewed in line with a model of care development and congruence with a positive behaviour support model.

The centre was transitioning to a culture and model of looking more at the underlying drivers for behaviours and had access to advice and guidance from a consulting counselling psychologist. The files had documents called 'individual care approaches' devised in response to problematic areas of complex behaviours and these were advised and reviewed with the psychologist. The psychologist had also participated in a significant event review for a placement that was at risk of breaking down. Inspectors found that the staff were interested in and engaged with the young people and were motivated to develop the new model and add to their skills development through internal and external training opportunities.

The centre staff team and their manager had good practices in place with regard to some risk assessments, individual crisis management plans/ICMP's, individual absence management plans/IAMP's and other one off safety style plans, these were devised, reviewed fortnightly and known by all staff. One aspect that inspectors noted was that for young people with clinical diagnoses, who were in receipt of medication or had specific medical needs such as asthma their ICMP's must state if physical restraint can be implemented and how, clinical advice must be sought in these instances.

Inspectors found that there were records maintained of sanctions and that sanctions were regularly utilised. At times sanctions caused confusion for the team where it related to a behaviour proving resistant to change or where a behaviour was recurring frequently this lead to potential over-layering of sanctions. The staff team discussed this at a team meeting and maintained a sanctions register to support tracking. Inspectors also found that the use of sanctioning for matters occurring in school did not present as a natural consequence but rather an additional sanction to that

imposed by the school. On another occasion it was noted on a record of a serious incident that during an incident a sanction was agreed that potentially breached the centres own procedures on the sanctions that should not be used, namely: 'Young person's bedroom being associated with any form of punishment or sanctioning'.

Inspectors recommended that the centre review and enhance their policy commitment to evidencing the use of natural consequences and to expand the reinforcement of positive behaviours through a wider variety of means. The centre should also look to reviewing the effectiveness of sanctions and where not working implement additional wraparound interventions to address the underlying drivers for behaviours. Whilst auditing had taken place the senior service manager and director had not had the opportunity to do a full qualitative review of outcomes and behaviour management. They stated that they were focused on further enhancing their auditing and compliance model to incorporate additional personnel.

The centre had a policy on restrictive practice, the principle of restrictive practice was known by staff and management. The staff struggled to name practices that were or could represent a restrictive practice and this must be addressed both in the policy and at team level to ensure a good understanding exists of all matters that meet the criteria for a restrictive practice. The centre did not maintain a restrictive practice log and did not evidence a broad range of use of restrictive practices overall. There had been three episodes of the use of restraint and these had not been reviewed and therefore not examined for compliance or not with policy on the use of restraint or with compliance with the policy on restrictive practices. The episodes of restraint were not subject to review either with regard to the child's experience, staff practices and learning for practice going forward. A young person reported to inspectors their experience of feeling increased anxiety, feelings of claustrophobia and too many adults being present during restraint.

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

The centre staff noted that they utilised their handovers, team meetings and supervisions to raise concerns and identify areas for improvement. They were familiar with the senior service manager and the director and knew that they could approach them should they require. There had been no concerns raised with the centre manager or the senior team by staff. A sample of supervision records supported that practices were discussed and problem solving promoted to address any minor areas of difference. There were young people's meetings held and two of

the three young people who completed forms were positive about their care. The third young person was significantly critical of the care they received and these issues have been forwarded through the relevant channels. The fourth young person did not wish to give feedback at the time of the inspection. Inspectors briefly met two of the young people and observed them interacting positively with staff and the young people were welcoming with us. The social workers for the other young people stated that to date where an issue was raised with them by their young person or a parent that when brought to the centres attention it was responded to and acted upon following engagement.

The centre had a suitable policy on reporting of significant events and all parties noted and it was evidenced on file that reports were submitted in a timely manner to the relevant professionals. The staff created a hard copy for the young person's folder and noted who was notified and how, parents were generally notified by phone, the professionals through email. The significant events were entered onto a register thereafter.

The centre team did not evidence completion of internal significant event review and external significant events reviews did not have a guiding set of criteria for when they would hold a review group and why. This left some gaps in meeting governance and learning from patterns goals that the centre had set for themselves.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 3.1** **Standard 3.2** **Standard 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- The senior management team must update the child protection and safeguarding polices to include the roles of mandated and non-mandated

persons and to identify how information that does not meet the threshold for reporting is tracked and recorded at the centre.

- The centre staff team must ensure that they deliver safe internet awareness work and address key areas of vulnerabilities through structured key work and interventions.
- The external management must review sanctions with the centre management in order to evidence learning, trends and effective outcomes for young people.
- The registered proprietor must establish a timeframe for the review and expansion of the model of care. The outcomes from audits, feedback and placements should inform this process.
- The centre manager must ensure that they review the restrictive practice policy and look at what constitutes a restrictive practice, what practices they do have in place and how they can best record and track these.
- The centre management and the external management must ensure that restraints are appropriately reviewed from a safety, accountability and rights based perspective.
- The internal and external management must establish clear mechanisms for reviewing and recording of significant events reviews.

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

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

The centre manager, who took up their post in January 2021, and their deputy demonstrated internal oversight of records and had systems in place to review and sign off on all types of written work. They attended and convened key meetings related to young people's care and positive feedback was received by the inspectors about the management at the centre. The centre manager reported formally to the senior service manager and director with a weekly operations report.

The senior service manager attended de briefs and staff appraisals, they gave feedback on significant events, some sanctions and attended a staff meeting from time to time. They visited regularly and were known by staff and young people. The director of services was also familiar with the centre and had visited regularly, both external managers informed inspectors that they had spoken with young people individually from time to time. There were monthly senior manager's meetings held,

although recorded and well-structured in format the minutes were limited in the key areas that related to external governance of complaints, concerns and allegations.

The senior service manager and their director had established an auditing system designed to measure practice against the National Standards for Children's Residential Centres, 2018 (HIQA). Copies were provided for review by inspectors, since late 2019 these audits had been quarterly and in this initial phase mainly quantitative. There were actions identified for areas of improvement but the detail of what led to some of the more significant actions and what changed thereafter was not captured in this format.

Inspectors found that there must be better evidence of analysis and learning from complaints, concerns and allegations. The team meeting minutes, audits and external management meeting minutes did not clearly and robustly evidence this. There must be more evidence of the voice of young people and outcomes from placements being reviewed to promote improvements and support better outcomes as the centre develops. The matter of the review of the model of care and how it interplays with the management of behaviour that challenges should be completed without undue delay and be informed by any trends and learning from practices to date. An annual review of compliance had not as yet been completed for 2020 and should be completed with key objectives set out.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5**

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

Actions required

- The registered proprietor and external management must put arrangements in place to robustly evidence governance, oversight and learning from complaints, concerns and allegations.

- The registered proprietor must ensure that there is adequate evidence of the voice of young people and outcomes from placements being reviewed to promote improvements and support better outcomes as the centre develops.
- The registered proprietor must complete an annual review of compliance.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1.6	The registered proprietor must ensure that the systems and model in place at the centre takes account of a children's rights and consultation based focus in order to inform practice development.	The registered provider will ensure that 24hr Care Services Model of Care will take into account and consideration at all times the rights of the children and to continue to consult them on all matters pertaining to service provision to inform practice development. The Model of Care will be implemented, and all staff trained by the end of September 2021.	The registered provider along with the senior management team will ensure that the Model of Care will be rolled out initially to the management team and feedback will be provided. All staff teams will be trained by the end of September. A full review will take place by the end of November.
	The registered proprietor, their senior management team and the centre management must ensure that the policy on complaints is reviewed with the procedures and categories clarified. The staff team must be trained in the revised policy on complaints.	The registered provider along with both senior and centre management teams have completed a comprehensive review on the complaints policy. The centre managers have committed to committing at team meetings to ensure staff are trained in any revised policies.	The Company Director and Service Manager will ensure governance that any revised policies are discussed at team meetings to ensure all staff are aware of same.
	The centre manager must review their recording of all types of complaints and	The senior management team have reviewed all aspects of recording	The Company Director and Service Manager will ensure effective governance

	establish the means through which social workers are made aware of the different types of complaints and concerns.	complaints. While we do this, we have implemented a more robust system to evidence this practice. Through the review we have identified shortfalls in evidencing complaints. We have incorporated a complaints section in the young person's placement support plan which are sent to Social Work Teams on a fortnightly basis. We have also devised an internal complaints form for each young person to include if the young person was happy with the outcome and that the Social Worker was notified. If the young person is not happy with the outcome this in turn will be escalated to an external complaint.	and oversight to ensure all matters pertaining to our complaints systems are robustly monitored and reviewed.
	The centre management must review the registers in place to record and track all types of complaints in line with the policy and procedures.	The senior management team have reviewed and updated the registers of complaints. The registers are updated to enhance the recording and tracking of all types of complaints in line with our Policies and Procedures.	The Company Director and Service Manager will monitor and oversee the registers within the centre through the auditing process to ensure effective recording and tracking ensuring the voice of the young person is heard throughout the complaints process.
	The registered proprietor must ensure that auditing addresses root causes of	The registered provider will ensure that the auditing processes takes into	The company Director and Service Manager will ensure that all auditing

	all types of complaints and the quality of the processes they have in place to address complaints.	consideration all root causes of complaints, ensure processes have been followed through our auditing policy. The Senior management team have updated the auditing form to include the voice of the young person to enhance better outcomes for young people.	completed will be discussed in more detail at senior management meetings and manager meetings to ensure effective learning is shared.
2	The centre manager must ensure that the young people's booklet is reviewed to ensure it is child friendly, cohesive and accurate. The centre manager must review, with the team, the risk assessment and management of risk document, the use of scoring, its purpose and role in the through placement risk and safety planning. The centre manager must ensure that the goals in the placement plan reflect the referred needs of the young people.	The senior management team has reviewed the young person's booklet and updated to ensure it is child friendly, cohesive and accurate. The senior management team have reviewed this document regarding its purpose and role. We will incorporate this document throughout a young person's placement. We will continue to review scoring through their placement in consultation with relevant parties. The centre manager will ensure going forward that any referred needs or vulnerabilities will be reflected on the	The senior management will ensure oversight and governance of the young person's handbook. The Company Director and Service Manager will ensure oversight and governance of the risk document throughout a young person's placement to ensure effective risk management and safety planning. This document will be reviewed at the next senior management meeting to ensure effective use. The senior management team will ensure effective oversight and governance of placement support plans through auditing

		young person's placement support plan in consultation with the Social Worker.	and attendance at team meetings to ensure all needs are clearly reflected.
	The centre staff team must ensure that the key work goals are assigned where possible to named persons in the first instance and then tracked through the intended case management process.	The centre manager will ensure that all key work goals are assigned to an individual staff member. The key worker will ensure that these goals are attainable and tracked to ensure oversight. Case management by the centre management team will ensure further oversight and governance.	The senior management team will ensure that all key work sessions are tracked through the case management form for oversight and governance. This case management form will be reviewed at senior management meetings to ensure the effectiveness of the key working in all centres.
	The centre staff must work to ensure that the records of key mechanisms like a team meeting are professionally maintained and actions reviewed to support safe care and support for young people.	The centre manager will ensure that all records deriving from any team meetings are professionally maintained to a high standard. Going forward the centre manager will ensure that all minutes are typed up to ensure effective safe care and support for our young people.	The senior management team will ensure effective oversight and governance and will review team meetings on a regular basis to ensure comprehensive quality discussions are recorded.
	The registered proprietor must satisfy themselves that all reasonable efforts have been made to resource the placements in order to meet the placement plan goals.	The registered provider is satisfied that all necessary resources are in place to meet the placement plan goals for each young person.	The senior management team in consultation with the centre manager will ensure effective resources are in place in the centre through the weekly manager's reports. These are received via our internal

			Communication system.
	The maintenance team must implement a structured approach to pest control measures at the centre. The centre manager must thereafter satisfy themselves that these measures are adequate for the property.	The Maintenance team have a robust pest control system in place which includes weekly checks in relation to pest controls. If required, we will outsource the necessary resources to ensure effective pest control.	Senior management team have identified an assigned person to ensure effective oversight on all matters pertaining to pest control within the Maintenance team. All matters pertaining to maintenance and Health Safety are discussed at Senior management meetings.
	The centre manager must review the files and secure in a safe manner all pre admission confidential information.	At present all referral information is stored in a master file in a fireproof locked cabinet in the centre manager's office. A working group has been identified to robustly review our files to ensure all parts of the file are stored in the correct manner. This will be completed by the 23rd of July.	The outcome of this review will be overseen by senior management. Through the auditing process any shortfalls relating to the storage of files will be addressed.
	The centre manager must secure or remove sensitive materiel gathered as evidence and seek advice from Gardaí and the social work departments in doing so.	The centre manager has removed any sensitive material and sought clarity and advise from the Gardaí and relevant Social Worker.	The senior management team will ensure going forward that any material of a sensitive manner will only be kept on file if advised by the Gardaí and Social Work Department.
	The senior management team must	Where possible exit interviews will take place with young people, families and	The senior management team will ensure that this framework is followed and will

	develop a system of information gathering from young people, families and relevant professionals once placements have ended in order to inform the ongoing development of the centre.	relevant professionals to ascertain ongoing development of service provision. We will devise a structured framework around same that will be used for better learning and outcomes.	inform ongoing development. Through the development of our Model of care and framework associated with same, this will allow us more opportunity to gain feedback from young people, families and relevant professionals to gain better insight and learning to enhance service provision.
3	The senior management team must update the child protection and safeguarding polices to include the roles of mandated and non-mandated persons and to identify how information that does not meet the threshold for reporting is tracked and recorded at the centre. The centre staff team must ensure that they deliver safe internet awareness work and address key areas of vulnerabilities through structured key work and interventions.	The senior management team and the centre manager in consultation with the relevant social worker will determine what information is deemed to meet the threshold for reporting through the CPN system. This information is recorded in the young person's file. The senior management team have updated the relevant policy to reflect the roles of the mandated and non-mandated persons. All young people are encouraged to complete the Lockers programme which includes safe online awareness. The centre manager will ensure that all young people are encouraged to engage in safe internet	The senior management team have updated the relevant policy and will be circulated to the staff teams for review. All policies will continue to be reviewed and updated as required by the senior management team. The centre manager will ensure any changes to policy are discussed at team meetings to ensure all staff are aware of same. As a further preventative measure all staff across the centres are scheduled to complete Child Protection Refresher Training. The senior management team will ensure that all key work sessions are tracked through the case management form for oversight and governance. This case management form will be reviewed at

		awareness work. This is addressed through their Placement Support Plan and Key working sessions.	senior management meetings to ensure the effectiveness of the key working in all centres.
	The external management must review sanctions with the centre management in order to evidence learning, trends and effective outcomes for young people.	The senior management team have reviewed their policy on sanctions and the use of same by the centre teams. We accept that the use of sanctions has been excessive and the senior management along with the centre management team have a large current focus on addressing this within the centre.	The Company Director and Service manager will review sanctions on an ongoing basis through the auditing processes. It is hoped through the implementation of the Model of Care and current focus that sanctions will decrease thus in turn ensuring better evidence of learning and effective outcomes for young people. All staff teams will be trained by the end of September. A full review will take place by the end of November.
	The registered proprietor must establish a timeframe for the review and expansion of the model of care. The outcomes from audits, feedback and placements should inform this process.	24hr Care Services Model of Care will take into account and consideration at all times the voice of the children and to continue to consult them on all matters pertaining to service provision to inform practice development. The Model of Care will be implemented, and all staff trained by the end of September. The model framework will incorporate outcomes from audits,	The senior management team in consultation with our in House Psychologist have currently devised our Model of Work. Consultation and the framework associated with the Model of Care is at the final stages of implementation. The senior management team along with our In house psychologist will ensure that the Model of Care will be

		placements and feedback from young people.	rolled out initially to the management team and feedback will be provided. All staff teams will be trained by the end of September. A full review will take place by the end of November.
	The centre manager must ensure that they review the restrictive practice policy and look at what constitutes a restrictive practice, what practices they do have in place and how they can best record and track these.	The senior management team have reviewed policies and current practices as a result we have updated the restrictive practise policy to identify what constitutes a restrictive practise and how to fully implement this policy across this service.	The Company Director and Service Manager will ensure governance that any revised policies are discussed at team meetings to ensure all staff are aware of same. Any revised policies will be reviewed at the next senior management meeting.
	The centre management and the external management must ensure that restraints are appropriately reviewed from a safety, accountability and rights based perspective.	The centre management in consultation with the senior management team will ensure that all restraints are reviewed as soon as possible after the event from a safety, accountability and rights-based perspective.	The Company Director and Service Manager will ensure going forward that any use of physical intervention a SERG meeting is carried out to ensure accountability and learning. The centre manager will ensure that all learnings are discussed at the team meetings. This will be monitored through the auditing process and attendance at the team meetings by senior management.

	The internal and external management must establish clear mechanisms for reviewing and recording of significant event reviews.	The senior management team have a schedule of dates for SERG meetings for the rest of 2021. All SERG meetings will be discussed at senior management meetings and learnings relayed back to the staff team at team meetings.	The Company Director and Service manager will ensure effective oversight and governance of SERG meetings through auditing and attendance at team meetings. All SERG's will be recorded on an internal form to ensure effective recording and review.
5	The registered proprietor and external management must put arrangements in place to robustly evidence governance, oversight and learning from complaints, concerns and allegations. The registered proprietor must ensure that there is adequate evidence of the voice of young people and outcomes from placements being reviewed to promote improvements and support better outcomes as the centre develops.	The registered provider in consultation with senior management will ensure that adequate reflective recordings of all discussions at team meetings, audits and external management meetings will be evidenced to show the review and learning from complaints, concerns and allegations. The registered provider along with the senior management team have updated and reflected the paperwork to adequately take into consideration the voice of the young people to promote and support better outcomes for the centre through the auditing process. The Model of Care framework will incorporate outcomes from audits, placements and feedback from	We have amended our recording systems to ensure that adequate recording of discussions and learning are robustly evidenced. As a further preventative measure all staff across the centres are scheduled to complete Child Protection Refresher Training. The senior management have developed a mechanism that supports and evidences the young person's voice through their placement. Through the review and updating of our policy and procedures and auditing systems we will endeavour to achieve and ensure effective evidence of the voice of the young person and will achieve better outcomes as the centre

		young people.	develops.
	The registered proprietor must complete an annual review of compliance.	The registered provider will ensure that the annual review of compliance is completed in August for review.	The company Director and Service Manager will ensure that the annual review of compliance is conducted and recorded in August annually going forward. All aspects of service delivery will encompass our annual review of compliance to include learnings form recent inspections by ACIMS.