Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 150

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**13th & 14th April 2021**
Registration Status:	**Registered from 29th March 2019 to the 29th March 2022**
Inspection Team:	**Catherine Hanly** **Eileen Woods**
Date Report Issued:	**29th June 2021**

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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 29th of March 2019. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from 29th March 2019 to the 29th March 2022.

The centre was registered to provide specialist therapeutic care and accommodation to a maximum of four young people of both genders from age 10 to 14 years on admission, up to 18 years of age. The programme of care was identified as being of one year minimum in length. Exceptions outside of this age range were permitted in line with the Alternative Care Inspection and Monitoring Services (ACIMS) derogation process governing same. At the time of this inspection there were four young people residing at the centre and two were outside of the centre's stated age range, one under ten and one over fourteen, both of whom had been approved by the ACIMS process referenced herein. The model of care was described as attachment and trauma informed with the inclusion of psychology, art psychotherapy, and education supports/resources as well as an accredited experiential learning provision. It also included the recently implemented CARE framework (children and residential experiences, creating conditions for change).

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.1 & 2.5 only
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.3 & 5.4 only

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

how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. Due to the emergence of Covid-19 this inspection was carried out through a blend of an onsite visit, review of documentation and interviews via telephone.
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 to the relevant social work departments on the 12th of May 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 was used to inform the registration decision. The centre manager returned the report with a CAPA on the 14th of June 2021. 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 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 150: without attached conditions from the 29th March 2019 to 29th March 2022 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 2.1 Each child's identified needs inform their placement in the residential centre.

The centre had a written policy on admissions that took account of the rights of young people to have a planned process in accordance with their individually identified needs. It acknowledged the centre's ethos and care approach but lacked specific reference to relevant aspects of the centre's statement of purpose such as age range and minimum length of stay. The policy was in accordance with referring mechanisms currently in place and took account of relevant legislation and guidance included therein. The pre-placement records that inspectors reviewed demonstrated that practice was in keeping with the policy and showed evidence of young people being provided with opportunities to meet staff, be provided with some relevant information about the centre and have an opportunity to visit it in advance of moving in. Social workers spoke highly of the efforts of centre management and staff in this regard.

Inspectors found evidence from interviews and files review, that interdisciplinary working between centre management and supervising social workers was undertaken to ensure that a thorough assessment of need took place prior to admission in an effort to ensure that the centre was suitable to meet the needs of each young person placed there. There was evidence in most cases, in particular through the group risk impact assessments undertaken in advance of each admission, to support the broad determination of appropriateness of placement as measured against the needs and rights of young people already living in the centre. However, inspectors did identify some discrepancies between the referring information and the group impact risk assessments that were not clearly accounted for and should have been included/updated particularly when considering the admission of young people whose age and purpose of placement were outside of the centre's statement of

purpose. Inspectors found that the information presented at the time of the inspection regarding the purpose of one young person's placement was different to the information that was presented to the Tusla Alternative Care Inspection and Monitoring Service for them to be admitted subject to the derogation process. The purpose of their placement at the time of the inspection was not aligned to the centre's statement of purpose in that the specified purpose for their placement was preparation to leave care within a nine-month timeframe. Whilst centre management were able to explain the rationale for this young person's placement at this centre, they must, through their various governance and review mechanisms, demonstrate that admissions of young people are closely in keeping with the centre's statement of purpose.

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

Inspectors found evidence of a number of mechanisms in operation that allowed for communication and cooperation between services and the centre that facilitated a partnership approach. These included regular informal and formal communication with and updates to supervising social workers of young people; agreements to provide regular updates to parents; regular formal review mechanisms for the purpose of reviewing statutory care plans; as well as strategy meetings to ensure that the service was able to deliver on outcomes for each young person.

At the time of the inspection, the centre had admitted a young person aged sixteen and whose plan it was to move on from the centre within an approximate period of nine months following admission. This placement, although in agreement with the supervising social worker and taking cognisance of the young person's individually assessed need and their own wishes, was not in accordance with the centre's statement of purpose in terms of its timeframe or its identified purpose. The young person had been allocated to the relevant social work team within their placing jurisdictional area that would support this young person through to aftercare. Although this placement and the young person's plan were both at an early stage of development, there was evidence to support that consultation with all parties had taken place and all involved demonstrated a confidence in the planning process towards a planned discharged and move on from this service.

The centre has discharged two young people since it commenced operations in 2019. Neither of these discharges were in accordance with the young person's care plan although both were in agreement with the supervising social work teams. Centre management did endeavour to put some structure and planning in place towards the

end of their placement in this centre in an effort to make the transition as coordinated as possible. Both young people were discharged to other centres operated by the service provider and their respective files and related information, including personal belongings and effects, transferred with them to the centre that they moved on to. Both young people were supported during their respective discharges and this support continued by staff from this centre for a period of time during their admission processes and early days residing in their new placements. Feedback from the young people on their experience of the placement or otherwise was not sought during or following discharge and this is a deficit that senior management within the organisation had acknowledged during an inspection of another centre within their operation and was a matter they intended to act on.

Compliance with Regulation	
Regulation met	**Regulations under this section not examined**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**None identified. Not all standards reviewed**
Practices met the required standard in some respects only	**Standard 2.1** **Standard 2.5**
Practices did not meet the required standard	**None identified. Not all standards reviewed**

Actions required

- Centre management must demonstrate that admissions of young people is closely in keeping with the centre's statement of purpose.
- Centre management must develop and implement systems of feedback for young people that leave 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 organisation's child protection and safeguarding policy was updated by the organisations policies and procedures subcommittee in March 2021 and was found to be in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015. The policy document encompassed detail on definitions of abuse, roles of specific persons in the centre/organisation including the Designated Liaison Person and mandated persons as well as the procedures in place for reporting child protection concerns. There were also guiding policies on and procedures for the recruitment and selection of staff, whistle blowing, lone working, anti-bullying, complaints and the staff professional code of behaviour. Policies and procedures relating to electronic communication and the internet and social media were also in place. Inspectors found that where matters of a child protection nature had arisen, staff and management in the centre had complied with the relevant policies and legislation referenced here.

The centre had a child safeguarding statement that had been approved by the Tusla Child Safeguarding Statement Compliance Unit and was on display in the staff office. Inspectors found that the manager and staff were familiar with the content of this statement. The centre manager held the role of designated liaison person (DLP) and the deputy centre manager held the deputy DLP role. Only the deputy manager had completed DLP training and inspectors recommend that the centre manager complete this training also as best practice. Inspectors reviewed the staff training record and noted that three staff had not completed training in Children First with a further two not having completed this training since 2018 which was in another centre operated by the service as this centre was not opened. With regard to the Tusla E-Learning module: Introduction to Children First, 2017, three staff had completed this in 2018 and the manager in 2017, all in advance of this centre commencing operations in 2019. Centre management must ensure that all staff complete the relevant mandatory child protection training and that refresher training for the online learning module is completed also.

The centre had an anti-bullying policy which was brief but did include procedures for dealing with bullying, a clear distinction for when bullying behaviour became a child

protection matter and possible exploitation of young people on social media. Inspectors found a mixed view represented by staff regarding the occurrence of bullying at the time of the inspection. There were no formal records of incidents of bullying however the targeting behaviours of some young people towards others at times could potentially be deemed as bullying and centre staff and management must be vigilant to this and the impact of group living on all young people.

Inspectors reviewed the centres child protection and welfare reports register and noted that all child protection and welfare reports submitted via the online portal system to Tusla were documented here. All reports remained open at the time of the inspection although one had been notified more than five months prior to this inspection. The centre and regional managers had made efforts to pursue a conclusion and outcome on these with the relevant social workers. Responsibility for parental notification of child protection concerns was negotiated with supervising social workers.

Inspectors found evidence from various interviews and in records at the centre of a thorough risk assessment process being conducted at the pre-admission stage for all residents. This process, consisting of a detailed group risk impact assessment and consultation with all supervising social workers, was the initial point at which the identification of individual vulnerabilities took place. Further assessment and planning throughout the placement was recorded in individual safety plans, absence management plans and risk assessments. The interventions to safeguard young people, taking account of these vulnerabilities were delivered upon through a multi-partnership approach involving social workers, guardians and parents. Social workers were complimentary of the centre's input and work in this area of practice. The young people in the centre also had access to the organisation's therapeutic team and staff could seek their input also even if there was no direct work with young people. There was evidence that young people were being assisted and supported, in an age and developmentally appropriate way, to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. One young person highlighted to inspectors how much they had progressed within the organisation, although only recently resident in this centre, they were able to reflect and acknowledge the positive impact of their placement within the organisation and hopeful that their placement in this centre would prepare them adequately for the next stage in their life.

The centre manager was of the view that recent significant efforts to ensure awareness of the centre's policy and procedure on whistleblowing had paid dividend in that there was prompt reporting of concerns noted by staff. There was evidence of

the policy being discussed as a set agenda item at team meetings. Centre management must continue to ensure that all staff are aware of their reporting responsibilities and accountability for safe care practice at all times.

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

The inspectors found that a positive approach to the management of behaviour that challenges was promoted in practice and supported by a range of policies and procedures at the centre. These included policies on supporting behaviour change, on the management of challenging behaviour, on consequences and guidance on clinical and therapeutic interventions. In addition, the centre's trauma and attachment informed model of care supported these policies and guided staff in promoting a positive approach. The management and staff teams were knowledgeable about the approach to the management of behaviour at the centre and described it as effective. There was evidence that the approach to management of behaviour commenced via the pre-admission assessment process and evolved as the placement progressed and was documented in risk assessments, individual development plans and individual key working. There was a reported and documented attention to the importance of identifying underlying causes of behaviour and situational impacts on behaviour that challenged. There was evidence of awareness of mental health issues that contributed to behaviours displayed and evidence of systems in place for escalating significant behaviour issues to social workers and the therapeutic team to coordinate a multidisciplinary approach. Two of the young people informed the inspector that they had been assisted and supported by staff to manage their behaviours and to regulate their emotions. Inspectors found evidence to indicate that the centre' approach had been effective with some young people but not all. There had not been any formal audit of the approach by centre or senior management and this may support learning and development in this area. The registered provider must ensure that audits of the centres approach to managing behaviour that challenges take place in accordance with the National Standards for Children's Residential Centres, (HIQA) 2018.

Staff demonstrated a relatively good understanding of what constituted a restrictive practice although there was variance in the detail provided suggesting this was an area of review for management in order to ensure a consistent understanding and clarity of recording of the use of same. Physical restraints had been carried out for some of the young people residing in the centre at the time of the inspection and for both of the young people that had been discharged. These physical interventions

were documented in the centre's significant event register and reviews of the events had been undertaken by the significant event review group (SERG) in accordance with the centre's policy. The regional manager stated that physical interventions were recorded on the centre's restrictive practices register however inspectors found that this was not evident at the centre. The inspectors reviewed a sample of physical intervention records and their associated review at SERG and noted some inconsistences in these records. For example, the length of time the physical intervention was deployed was not always documented and where this was absent, this was not picked up at the SERG meeting. In addition, the commentary within the SERG meeting did not consistently note whether the physical intervention deployed was in accordance with the young person's individual crisis support (previously management) plan (ICSP). The regional manager indicated that the format for the review of these events had been updated however centre management must ensure that the review minutes are consistently and accurately recorded to support robust oversight of the use of these interventions.

The staff team had completed training in a recognised model of behaviour management and were provided with ongoing regular refresher training. A review of the centre's training record indicated that some staff had exceeded the date for refresher training and inspectors are cognisant of the impact of the Covid-19 pandemic on facilitating training. One staff member was on leave and a further two on suspension so their training would be updated when they returned to work. Centre management indicated that they have scheduled dates for the remaining two members of staff that were actively working in the centre at the time of the inspection. Centre management must continue to ensure that all staff are appropriately updated in their mandatory training. The centre's policy on the use of this training needs to be updated to reflect updated terminology.

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

As previously noted in this report, inspectors found evidence to indicate that recent discussion in team meetings to the centre's whistleblowing policy had supported the staff ownership of responsibility and accountability in this area of practice. There was evidence that the manager and staff team strived to create a culture whereby both young people and staff were encouraged to raise concerns and report incidents. It has also been previously noted in this report that a clear distinction needs to be made between child protection and complaint matters. Whilst it is important that young people have their voice heard, it is more appropriate that staff clearly communicate to the young people affected the steps that will be taken to address the

issue at hand and ensuring that all young people feel safe and protected within that. If a young person wishes to make a complaint after the fact, then that should be facilitated at that stage. There was ample evidence that the voice of the young person was encouraged through the key working system and also in the weekly young people's meetings. These latter records were inclusive of a recent agenda item that allowed young people to receive feedback from staff and respond to that feedback. Additionally, young people were supported and encouraged to have their voice heard at their statutory review process. The young people that spoke with the inspector expressed the view that they felt heard by staff and the manager at the centre.

There were mechanisms in place to allow parents and social workers to provide feedback or identify areas for improvement within the service. Social workers informed inspectors that where they had provided feedback in relation to service delivery this had been taken on board and overall social workers were extremely complimentary of their respective experiences of engaging with centre management. Inspectors spoke with the parents of two of the young people and both indicated that they had been provided with opportunities for progress updates on their respective child and to feedback to centre management. Both parents raised separate concerns with the inspector which related to their respective child's care and inspectors requested that centre management and the supervising social workers liaise with them to ensure that they feel heard and responded to regarding these matters.

The centre had a policy, that had been updated in February 2021 following feedback on an inspection of a service, in relation to the recording, notification, management and review of significant events. This policy was in line with regulations and national policy in this area of practice. The centre had additional supporting policies and procedures in this area of practice including risk assessment, unauthorised absences and engaging An Garda Síochána. Inspectors found that incidents were reported in a timely manner in accordance with the policy and social workers confirmed this finding. There was evidence that significant events were reviewed at team meetings on a consistent basis with feedback and learning and any relevant changes to practice noted therein. Staff members also referenced the importance of this aspect of reflective practice in guiding their work. Inspectors noted a high level of entries on the centre's significant event register. Some of this was attributed, by centre management, to one young person who had resided at the centre for approximately one year and had been discharged four months prior to this inspection. As noted previously, significant event review group (SERG) meetings were convened on occasion to review specific significant events, in particular those that included the use of a physical intervention. However, overall inspectors did not find sufficient

evidence of an adequately robust system of review of significant events at the centre by senior external management that supported learning and development. The registered provider must ensure that there is a robust system of incident review in operation in the centre and that learning from this is communicated to all staff.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

- Centre management must ensure that all staff complete the relevant mandatory child protection training and that refresher training for the online learning module is completed also.
- The registered provider must ensure that audits of the centres approach to managing behaviour that challenges take place in accordance with the National Standards for Children's Residential Centres, (HIQA) 2018.
- Senior management must ensure that significant event review group minutes are consistently and accurately recorded to support robust oversight of the use of these interventions.
- Centre management must ensure that all staff remain updated in mandatory training related to the use of physical interventions.
- The registered provider must ensure that the centre's policy on the use of physical intervention is reflective of updated terminology.
- The registered provider must ensure that there is a robust system of incident review in operation in the centre and that learning from this is communicated to all staff.

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

Theme 5: Leadership, Governance and Management

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre had a statement of purpose which clearly described the model of service provision delivered. The statement was detailed and included information on the aims and ethos of the service, the range of services available to young people, arrangements for the wellbeing and safety of young people, and a list of relevant policies and procedures. The statement, although recently reviewed, did not include detail on the staff and management compliment in the centre and should include reference to same. The statement is publicly available and there was also a young person version. The document does not include specific information on the model of care though it is referenced in brief. Some explanatory detail would be of benefit, particularly when sharing this informational leaflet with relevant parties outside of the service.

Inspectors found that the management and staff team understood the model of care and were able to clearly explain this to inspectors including its application in everyday work at the centre. Staff also had a clear understanding of the centre's purpose and overall aims and demonstrated how the work of the centre contributed to the achievement of outcomes for young people.

The statement of purpose had been reviewed in March 2021 and inspectors found that broadly it was reflected in the day-to-day operation of the centre, in particular the ethos and the availability and input of specialist services to support the meeting of individual needs. Inspectors found that exceptions to the age range of the centre (10-14 on admission) had occurred, through a derogation process, on two occasions. Whilst one of these, for a young person aged seven at the time, was in all other ways in keeping with the centre's statement of purpose, the second was not. The derogation for a second young person aged sixteen at the time of admission was to support them towards independent living over a period of approximately six months. The statement of purpose outlines that the programme of care within the centre is for a minimum of twelve months. The regional manager acknowledged that this placement was in some ways a trial of a change in the centre's purpose and notwithstanding that it was deemed a positive move for this young person, it was also

noted that their placement in this centre facilitated a move for them from another centre within the organisation. Inspectors did not find evidence that the statement of purpose was being reviewed and evaluated as part of the centre's governance arrangements. As stated previously in this report, this matter must be attended to and planned for on an ongoing basis to provide assurances that services are being delivered in line with the statement of purpose.

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.

There was evidence of multiple forums within which the quality and safety of care provided to the young people in this service is reviewed including team meeting, senior management meeting, significant event reviews, and case reviews. Inspectors observed that the learning from these forums was communicated within the centre for the purpose of improving the direct care provided to the young people. In addition, the organisation has a governance committee and compliance officer in place.

The regional manager and the compliance officer had undertaken audits within the centre. Inspectors reviewed a sample of themed audits conducted against the national standards however it was noted that there were limited audits completed against the current national standards and the regional manager informed inspectors that the Covid-19 pandemic had impacted on the auditing systems in place. From this review, inspectors found that the audits lacked relevant detail including identifying the person responsible for completing the audit and lack of specific detail that would support the findings documented. The accompanying action plans lacked timeframes, identification of persons responsible for completing the actions required, and needs to be more measurable from a governance perspective. Inspectors note that there are improvements required to the current system of audits to ensure that there is adequate and robust assessment of the safety and quality of care provided in this centre as measured against the National Standards for Children's Residential Centres, 2018 (HIQA).

Inspectors did note that on a case by case or individual event basis there was evidence of recording and acting on complaints and child protection matters. Inspectors reviewed an audit completed in January 2020 of complaints and child protection concerns. This audit was more a file review to establish whether or not the matter had been closed and thus could be acknowledged within the relevant file. The

report did not demonstrate an examination and analysis of trends in this area of practice and the registered provider must ensure that information relating to complaints, concerns and incidents is monitored and analysed in order to promote practice improvements.

The centre manager acknowledged that an annual review of compliance with the centre's objectives has not yet been undertaken and is aware of the requirement to do this. The registered provider must ensure that such a review is undertaken and that whatever actions required as a result are undertaken in order to promote improvements in work practices.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified. Not all standards reviewed**
Practices met the required standard in some respects only	**Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**None identified. Not all standards reviewed**

Actions required

- Centre management must review the centre's statement of purpose to include relevant detail on the centre's model of care and the compliment of staff within the centre.
- The registered provider must implement the necessary improvements to the current system of audits to ensure that there is adequate and robust assessment of the safety and quality of care provided in this centre as measured against the National Standards for Children's Residential Centres, (HIQA) 2018.
- The registered provider must ensure that information relating to complaints, concerns and incidents is monitored and analysed in order to promote practice improvements.
- The registered provider must complete an annual review of compliance and oversee the implementation of any actions identified therein.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	Centre management must demonstrate that admissions of young people is closely in keeping with the centre's statement of purpose. Centre management must develop and implement systems of feedback for young people that leave the centre.	With immediate action. SOP&F updated in May 2021. This will be brought to the attention of senior management and to all centre managers/regional managers for further discussion and consultation.	Consistent review alongside centre management and regional management. Review mechanisms also in place via the governance committee where all updated SOP&F's will be ratified. The organisations subcommittee for policy & procedures have devised a feedback form for all young people leaving the service. This will be completed alongside their Social Workers so that it is independent from centre staff. Once all managers in the organisation have had a chance to review same, this new form will be ratified at the governance committee on the 24.6.2021.
3	Centre management must ensure that all staff complete the relevant mandatory child protection training and that refresher training for the online learning module is completed	With immediate effect. Since the time of inspection Centre Management have either put training dates in place or have a clear plan outlining the next training dates for staff. E learning for staff will be re-	Regular consultation with the training team re: outstanding training for staff. Since the inspection the training team now have an additional trainer as the organisation has grown and this will help

	also.	established once the HSEland is back up and functional.	with tracking same.
	The registered provider must ensure that audits of the centres approach to managing behaviour that challenges take place in accordance with the National Standards for Children's Residential Centres, (HIQA) 2018.	Audit process to be reviewed over the next 2 months to ensure recommendations from inspections are included in same.	The compliance officer will now sit in on the feedback for inspections going forward. A review of the current template structure being utilised will be reviewed by the compliance officer and brought to the governance committee for discussion.
	Senior management must ensure that significant event review group minutes are consistently and accurately recorded to support robust oversight of the use of these interventions.	With immediate effect. A new recording template has been devised which has been implemented.	Regional management alongside the SEN team will ensure continuous review of minutes recorded. The Director of Care & Quality will ensure oversight of this process.
	Centre management must ensure that all staff remain updated in mandatory training related to the use of physical interventions.	With immediate effect. This will be overseen by the TCI lead.	As the organisation has grown, we have now put in place an additional 20 TCI trainers. This means that each centre will have a dedicated TCI lead for their centre who will assist centre management in ensuring that all mandatory training in respect of TCI is adhered too.
	The registered provider must ensure	Actioned.	The policy was updated in February 2021

	that the centre's policy on the use of physical intervention is reflective of updated terminology. The registered provider must ensure that there is a robust system of incident review in operation in the centre and that learning from this is communicated to all staff.	 As discussed above. With immediate effect. A new recording template has been devised which has been implemented. The learnings from same are shared with the team via handover and team meetings.	but was overlooked. On the back of this inspection this policy has now been ratified by the governance committee and is in place. The SEN team will ensure that they receive feedback from centre management showing evidence of how learning is communicated with all the staff to attach to their records. The SEN team will ensure that records are not signed off on until this process is complete.
5	Centre management must review the centre's statement of purpose to include relevant detail on the centre's model of care and the compliment of staff within the centre. The registered provider must implement the necessary improvements to the current system of audits to ensure that there is adequate and robust assessment of the safety and quality of care provided in this centre as measured against the National	Actioned. Following on from this inspection all SOP&F's across the organisation where updated. This has been furnished to all management and staff. As discussed above. Audit process to be reviewed over the next 2 months to ensure recommendations from inspections are included in same.	Ongoing review via the governance committee. Any changes/updates required will be discussed at the governance committee and updates will be conducted by the policy subcommittee team. The compliance officer will now sit in on the feedback for inspections going forward. A review of the current template structure being utilised will be reviewed by the compliance officer and brought to the governance committee for discussion. We have highlighted the need for extra

	Standards for Children's Residential Centres, (HIQA) 2018.		resources being required to the compliance team and envisage the recruitment of a second compliance officer in the last quarter of the year.
	The registered provider must ensure that information relating to complaints, concerns and incidents is monitored and analysed in order to promote practice improvements.	With immediate effect. All issues relating to complaints, concerns and incidents are logged in a weekly operational report that is sent to senior management.	Regional management will continue to review same via supervision with the centre manager and monthly home visits. The Director of Care & Quality will conduct a check in with the regional team on a weekly basis and these items will become part of that check in.
	The registered provider must complete an annual review of compliance and oversee the implementation of any actions identified therein.	This will be in place within the next 2 months as the compliance officer reviews same across all homes.	Our compliance officer will ensure that an annual review of compliance is in place for this home. The compliance officer has recently conducted a presentation to management teams on same.