An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Year: 2020

Centre ID number: 153

Inspection Report

Year:	**2020**
Name of Organisation:	**Barróg Healthcare Ltd**
Registered Capacity:	**Two**
Type of Inspection:	**Announced**
Date of inspection:	**23rd 24th of September 2020**
Registration Status:	**Registered with conditions attached 08th of May 2019 to the 08th of May 2022**
Inspection Team:	**Eileen Woods** **Lisa Tobin**
Date Report Issued:	**30th April 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 08th of May 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 with attached conditions from 08th May 2019 to the 08th of May 2022, the conditions were attached following the onsite phase of this inspection process.

The centre was registered to provide care for a maximum of two young people aged over 16 and the model of care was relationship based. Training in an expanded model of care was booked for the staff team for the month of October 2020. There one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following aspects of themes and standards:

Theme	Standard
2: Effective Care and Support	2.1, 2.2, 2.3, 2.4, 2.5, 2.6
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.1

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 20th of October 2020 and to the relevant social work departments on the 20th of October 2020. An immediate regulatory action notice had been sent to the registered provider on the 5th of October 2020, this proposed to attach the condition of no new admissions to the centre. 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 3rd of November 2020. This was deemed to be unsatisfactory and the inspection service did not receive adequate evidence of the issues addressed. A second CAPA was requested on identified issues and the responses to these inclusive of some evidence was completed by the 18th of November 2020. A meeting was held with the registered provider and the centre management with the regional inspection and monitoring service manager on the 18th of November 2020. Following evaluation by the Registration Panel the centre was referred to the Tusla National Registration and Enforcement Panel, NREP, on the 15th December 2020. A meeting was held by the NREP with the registered proprietor on the 21st of January 2021 and a notice to attach conditions to the registration of the centre was issued to the registered provider on the 16th of February 2021.

The findings of this report and assessment of the submitted CAPA deem the centre to be not 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:153 with attached conditions from the 8th of May 2019 to the 8th of May 2022 pursuant to Part VIII, Article 61, (11) (A) 1991 Child Care Act.

The attached condition being:

- The registered capacity of young people will remain at one until April 31st 2021.

3. Inspection Findings

Regulation 5 Care Practices and Operational Policies
Regulation 8 Accommodation
Regulation 13 Fire Precautions
Regulation 14 Safety Precautions
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 that was not implemented fully in practice at the centre. The policy outlined robust procedures such as a referrals committee and a needs assessment process that were not evidenced on file. The policy omitted reference to the pre-admission individual and collective risk assessment that was in place to support suitable admissions and through-placement risk management and response. The pre-admission and admissions file presented for inspection for the newly resident young person did not contain referral information, a fully completed pre-admission risk assessment or a full record of the transition process. A pre-admission risk assessment completed by another service was on file. This and other documents had identified key areas related to specific high risks but these had yet to be addressed in a cohesive manner on the records. The centre's statement of purpose was not clearly expressed about the service on offer and the numbers and age range of young people and must also be updated.

The centre management and the operations manager informed the inspector that due regard was given to the suitability of the service for the young person and the social worker for the young person provided verbal evidence that such discussions took place. A focused and recorded assessment of need process was not on file and the social worker and the management stated that a verbal discussion along with the care plan represented their agreed initial assessment of what was required for the young person. Inspectors did not find that the written documents represented the known risks and consequent short or long term needs and this must be improved on the planning documents.

The social worker and the centre management informed the inspectors discussions had occurred regarding the suitability of the service for the young person and the best

timing for admission. It was also reported that this took account of the mix of young people giving appropriate weight to the needs of both parties. Three young people had been admitted since the opening of the centre and had fit the core criteria of being over sixteen, all three to date had been aged seventeen, and had previously experienced multiple placement breakdowns. There was evidence on file of some of the pre admission meetings and communication with the family, the young person and key professionals including the allocated social worker. The records on file did not represent a cohesive account of the process, were not in accordance with the policy and did not yet evidence an approach to assessment of need.

The current young person and their family had been informed about the centre, had met with staff and had visited the centre. Members of the staff team were reported to have worked with the young person for a month prior to the admission on a respite basis at locations other than the centre. However, this information was not recorded on the file and should have been utilised to further inform the admission and placement planning for the young person.

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

The social work department for the current young person had completed a statutory child in care review upon admission, a copy of this was on file. A copy of the care plan was also on file and an updated care plan was due to be provided to the centre. The child in care review identified the core goals for the centre to put into action. The young person attended their review and was fully involved in the process. The social worker stated that they had been provided with verbal feedback and some written communications outlining the centres initial responses to the goals identified and that they were satisfied with the work so far. There were copies of care plan reviews on file for the previous young person.

The current young person had been in placement for three weeks at the time of the inspection with an additional pre admission phase. The manager stated to inspectors that it was not the centre's policy to complete a written placement plan until they became familiar with a young person and had consulted fully with the young person and their family. The previous young person's file contained copies of placement plans that were reviewed in line with statutory reviews or at three month intervals. Due to a lack of team meeting records (copies of minutes of two meetings were available) and the structure of supervision not being specific to placement plans it was difficult to track progression through placement plans. Given the specific nature

of the purpose and function of the centre inspectors recommend that the centre complete a process of assessment and planning without delay and that these be reviewed formally thereafter on a monthly basis. The daily logs evidenced actions regarding education, medical, activities and family that were directed by the centre manager and delivered by staff. The centre was in transition to a new model of placement planning and were also utilising a model of behavioural reward charts. They will need to assess the appropriateness and congruity of the model to the age range and commit to a structured model of preparation for leaving care.

Inspectors found evidence of referral to external specialists supports, of advocacy for clinical referral where needed and of active support for young people to try to keep them engaged with existing specialist resources they may have had. The allocated social worker for the resident young person was satisfied with the initial communication and work evidenced by the centre.

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 suburban property in a large town with good amenities, services and education and training resources. The house was domestic in style and layout with a small bedsit at the rear. The latter may at times be utilised for later stage preparation for leaving care. There were two bedrooms, living space and bathroom facilities, the house was adequately decorated, warm and furnished. The age and needs profile of the young people did not require outdoor play equipment and the front driveway and the rear garden were tidy and clean. On the day of the inspectors visit to the centre the premises were clean and the living spaces appeared comfortable. There were hygiene and infection control measures in place upon arrival at the centre and contact details taken as per advised Covid 19 procedures.

The centre maintained evidence on file of servicing of the fire alarm panel and there was a record of weekly fire alarm tests. The inspector found evidence of one fire drill in 2019 and one in 2020. Evidence of compliance with part B of the building control regulations was provided by a qualified engineer. There was no evidence of servicing of the fire equipment including the extinguishers, sensors and emergency lighting dating for 2019 or 2020. One fire extinguisher had a broken seal and the main emergency exit light at the front door was out of order. Each staff and young person had been inducted into evacuation procedures and assembly points but there was no evidence of fire training completed on site for the current team in 2020, training had been done upon opening in 2019. No evidence was presented of regular visual

inspection of fire safety equipment or exits and the inspector did not observe an evacuation plan displayed in the office area.

A safety statement and a full health and safety assessment had been provided for the centres registration in May of 2019. No evidence was found of follow up audits since then. The items identified for urgent action in the audit had been recorded as completed. There were some individual records of maintenance completed, the last record provided to inspectors was from 2019. There were daily cleaning records related to the pandemic management procedures but of the records presented for inspection these records stopped being completed in August 2020. There was an allocated person for health and safety and they had put infection control measures in place in response to the pandemic and a contingency plan was developed. Inspectors reviewed returns for hours worked and these suggested that staff moved between services within the wider company which raised questions for infection control and contact tracing. Of the five staff files reviewed none evidenced training in fire safety or in first aid, the management were aware of this and seeking to book them.

The centre maintains a car for staff and young person use and this was provided by a hire company, this company provided all car maintenance. The personnel files sampled by inspectors did not all contain copies of a valid driving licence and the manager must ensure that they audit this and maintain accurate records of who is qualified and insured to drive the centre vehicle.

A general proof of renewal of insurance was provided for this inspection and the operations manager has been requested to provide the detail of the type of insurance cover to verify that there is adequate insurance against accidents or injury to children.

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.

A file had been created for the resident young person. The file was secured in an office in a locked filing cabinet. There was no file index attached and no summary of information regarding the young person's personal details. There was no fully completed pre admission risk assessment and the file required structured review to organise the contents to a better standard. The file required a signed absence management plan in accordance with the joint protocol on young people missing from care. The centre manager and deputy manager were aware of the requirements

to have a copy of a birth certificate, a care order, a medical card and confirmation of immunisations, some were on file and the rest had been requested. The inspectors did not find social history documents or referral documents visible in hard copy on the files. The main staff team including the key worker did not have access to this locked cabinet and inspectors recommend that the working file be accessible to the core staff team to allow for them to appropriately plan for and record in the best interests of the young person.

Throughout the files and documents reviewed small errors such as initials of other young people or unidentified others were on file or on the records such as registers and personnel files. The files in general were disorganised and required attention to firstly reduce the risk of information being inaccurately recorded, stored or shared and secondly to support good governance of records for tracking, review and learning. Key areas such as complaints and outcomes following serious incidents were not easy to follow on the files and had not been the subject of internal or external company audit.

Inspectors were informed that a personnel file had been removed from the office, for several hours, by a young person. The staff member involved and present stated that it was their own personnel file with only their data present. There was no evidence of a formal discussion and decision to explore if the removal of the file was a data protection breach. There had been follow up with staff about office safety. The organisations policy on data protection should inform an internal review of this matter.

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

The operations manager had, in line with commitments made in the CAPA response to the last inspection in October 2019, established a quality and assurance committee which had met in February and April 2020 the agenda listed actions required in response to their previous inspection related to developments aimed to improve standards, governance and communication flow. There were no meetings since then due to the pandemic working arrangements within the service and inspectors were informed that this meeting would be recommencing in October 2020. There were records of some of the communications between the centre manager and the operations manager related to deficits in adequate and stable staffing to deliver a safe service for young people. There was also evidence of pre admissions risk assessment discussions and wider consultation for the move in of a previous young person and

for the discharges for both previous young people. Overall though the communications folder did not contain evidence of the full extent of the communications regarding the young people and the team that had taken place between the centre manager and the operations manager. There was limited evidence placed in the folder of direct communication with the proprietor. The service must establish clear, cohesive written records that evidence the communication and shared decision making internally that take place regarding the young people and resourcing of the centre. A social work department for a previous resident provided positive feedback to the centre regarding the placement, noting dedication and pursuit of good outcomes. There was evidence of ongoing communication with social workers during the placements. The social worker for the current young person was satisfied so far with the level of verbal communication and co-operation.

Both of the previous resident young people moved from the centre in a planned manner into aftercare arrangements agreed with their placing social work areas. The aftercare placements were provided by this service but at different locations. There was evidence of meetings and communications with the social work department for the most recently discharged young person. Their Tusla aftercare worker was involved and there was evidence of a co-ordinated approach to the discharge in what was a complex case.

The inspectors did not receive feedback from the previous young people but the file of the most recently discharged young person contained evidence of their views and their involvement in the decisions for their future. They had provided feedback to the staff in the form of a thank you after they had moved out. There was no formal mechanism as yet to incorporate learning from outcomes to inform future development but the staff were aware of the young person's views.

There had been no arrangements agreed as yet for the transfer of the previous files back to the social work departments but the centre manager was aware of the need to make enquiries with the relevant social work departments regarding same.

Standard 2.6 Each child is supported in the transition from childhood to adulthood.

There was evidence of the consultation with the previous young person in the lead up to their transition into supported aftercare. The aftercare worker, the social worker

and the centre met regularly and there was an aftercare plan in place and statutory reviews held in accordance with the regulatory requirements.

There were complexities in the planning for aftercare that were recorded to have caused some tension for the young person and the centre worked in consultation with the social work department to seek to address these. Both previous young people moved into supported aftercare arrangements with this service and several staff moved to support this work.

There was evidence of individual work and key work completed in accordance with the placement plan goals, these included tasks identified from the care plan reviews. Inspectors found overall that there was a lack of a structured leaving care model for staff to follow. There was a focus on trying to integrate part of a new therapeutic model that included skills for life but the staff team had not trained in this model as yet and therefore did not represent an identifiable cohesive preparation for leaving care programme. Inspectors acknowledge that the individual complex needs of both previous residents presented specific challenges to the young people and the staff in seeking to complete this work. Inspectors also acknowledge the creative approaches utilised to harness young people's interests as a means to engage them in such work.

The lack of cohesive records reflective of the core purpose and function of the centre and the lack of management meetings related to operations and review made the tracking and assessment of the work completed difficult for inspectors to accurately track.

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

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 2.5**
Practices did not meet the required standard	**Standard 2.3** **Standard 2.4**

Actions required

- The operations manager and proprietor must review and strengthen the admissions policy and procedure to reflect the practices on pre admission risk assessment.
- The centre manager must ensure that the required records of preadmissions processes are completed, recorded and filed to a good standard.
- The operations manager and the centre manager must ensure that they audit and oversee all aspects of admissions.
- The operations manager and the centre manager must establish a clear and cohesive system of needs assessment for young people's placement and implement this in practice.
- The centres statement of purpose and function must be consistent with the national standards for children's residential centres HIQA, 2018 and with the centres policy on admission.
- The operations manager and the centre manager must ensure that the training in the proposed model of care be commenced.
- The operations manager and the centre manager must review the placement planning process taking account of the stated purpose of the centre, the needs assessment process, timing and review schedules for those placement plans suitable to the needs of the young people.
- The registered proprietor must take action to audit and assure full compliance with Child Care (Standards in Children's Residential Centres) Regulations 1996, Article 13 Fire Precautions.
- The registered proprietor and operations manager must provide fire training for the staff team.
- The detailed insurance schedule confirming adequate insurance against accidents or injury to children must be provided.
- The centre manager must ensure that maintenance and cleaning records are kept up to date at the centre.
- The centre manager must ensure that a full health and safety audit is completed at the centre.
- The centre manager must maintain a copy of the driving licence of all those qualified and insured to drive the centre car.
- The operations manager and the centre manager must establish a system for the creation, maintenance, oversight and external audit of appropriate records in relation to children.

- The operations manager must formally review through to outcomes and actions the incident related to the removal of the staff file from the centre office.
- The centre management must co-ordinate and implement a structured programme for preparation for leaving care in line with the centres stated purpose and function.

Regulations 5 Care Practices and Operational Policies
Regulation 6 (1 and 2) Person in Charge

Theme 5: Leadership, Governance and Management

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.

Inspectors found that where certain crises arose for previous young people that the experienced manager, deputy manager and operations manager galvanised a response that displayed focus and dedication to the safest outcome for that young person. They worked in co-operation with social work, Garda and other professionals to achieve this. They sought wide consultation with Tusla as part of this. The inspectors found that outside of this that the type of systems and structures required to meet standards, regulations and create development and improvement in the centre were not evidenced fully. There was insufficient evidence that the registered proprietor put comprehensive actions in place to satisfy themselves that the centre was sufficiently resourced to perform its functions as outlined in policy, procedure, national regulations and standards.

The quality, safety and continuity of care was difficult to assess and track due to a lack of audit, management records, team records and incomplete registers. The registers of significant events, complaints and young people were incomplete. There was confusion as to who held the role of DLP, designated liaison person, under Children First, 2017 and the centre's child safeguarding statement had not been formally reviewed for compliance purposes. There were no records of discussions to explore if specific events met the threshold for reporting through the child protection and welfare reporting system. The centre manager must establish a formal record of the delegation of duties between them and the deputy manager and how their working hours are structured to support this. There were limited records of senior management meetings, there was no internal or external quality assurance and

auditing in place, there were no regular mandated reports required from the centre management to the external management. There were staffing changes, poor recruitment and vetting procedures and a number of unqualified and/or part time staff. There was no visible tracking of hours worked and where. The centre manager raised concerns to the operations manager in writing regarding staffing in recent months. The operations manager responded to the inspection service on behalf of the registered proprietor to state that they were acting to address the deficits in staffing.

Inspectors acknowledge that the operations manager and the centre manager met to implement actions in response to the CAPA from their last inspection. Policy development had taken place and the pandemic impacted meeting and action schedules that they had agreed regarding centre development. All the management parties interviewed were committed to put actions in place to strengthen the centre. These were evident too in the internal management meetings that were on record, these were held in February, March, April and May 2020, the agendas included the CAPA actions, team recruitment and Covid-19 guidelines compliance. There had been research into a suitable model of care and contact established with the consultant involved.

There were limited records of external senior service manager meetings provided for this inspection, one dated for 2020 was found on file and one undated, these contained relevant headings but few details related to policy development, planning and co-ordination, interagency working and other areas. Inspectors were not provided with evidence of a system for an annual review of compliance.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**One standard examined**
Practices met the required standard in some respects only	**One standard examined**
Practices did not meet the required standard	**Standard 5.4**

Actions required

- The registered proprietor and operations manager must implement a robust system for internal and external auditing to ensure oversight of the centre's care practices and operational policies and procedures. Legislation and national policy must be reviewed regularly and identified gaps in compliance must be addressed in a timely manner.
- The operations manager must ensure that the full policies and procedures development is completed in a timely manner. A structured programme a team induction should then be conducted.
- The centre manager must ensure that there is a record of any formal delegation of management duties and to whom.
- The operations manager and the centre manager must clarify and circulate to all staff the named person who holds the role of designated liaison person, DLP and as deputy designated liaison person, DDLP.
- The registered proprietor must ensure that there are formal arrangements in place to assess the safety and quality of care against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The registered proprietor and operations manager must ensure that there is specific monitoring and analysing of complaints, concerns and incidents. And that actions and outcomes are implemented in practice.
- The centre manager must ensure that up to date and accurate registers for significant events, complaints and admissions and discharges of all young people are maintained.
- The registered provider must ensure that an annual review of compliance with centre objectives is conducted and that it identifies specific actions to inform service improvement.

Regulations 6 Person in Charge
Regulation 7 Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors were not provided with details of a formal structure for workforce planning for the centre. There was not eight full time staff plus a manager in post during this inspection. There were policies for staff recruitment, development and training that had not been implemented in practice. The names and numbers of staff

presented for this inspection differed from that provided for the previous inspection in October 2019 and 26 different individuals were noted across various records as having completed hours at the centre in the twelve months since the last inspection. As was noted earlier in this report the numbers of hours returned for staff indicated that several staff worked a number of consecutive shifts. Whilst it had been an agreed internal policy that 48 hour shifts were allowed this was presented as relating to limited availability of qualified persons to fill rosters as opposed to other operational reasons. There wasn't strong evidence that on an ongoing basis that there were enough staff to cover annual leave, maternity leave and other types of leave. This was verified by the centre manager and the operations manager.

The compliment of a manager plus eight full time staff by time of this inspection included a social care leader who was no longer working there, two staff listed as full time who were part time and one or more staff who named that they also worked elsewhere. Further review identified that the qualification levels of two staff did not meet the minimum requirements. There were no identified relief staff.
These staffing arrangements included the experienced manager and deputy manager who worked hard, inspectors found, to meet the needs of the young people and build up a good service for young people. The managers stated that they did not have enough trained and experienced staff in post over the medium term to develop the centre in the manner they hoped to do. A young person had complained about staff qualifications, working hours and Covid-19 compliance and their social work department had investigated this matter, assurances were given that satisfied the social work department at that time.

The inspectors noted that some staff had experience, mainly in the disability sector but were motivated to gain experience in children in care. They received remote supervision and reflective practice sessions from the manager and the deputy manager as well as inductions completed by the deputy manager. They had not received core training as yet as a group and team meetings were in the process of being reformulated. The training in the model of care was booked to take place in the coming month. Other core training required urgent attention for completion also, for example, the chosen model for management of challenging behaviour. The inspectors reviewed a sample of personnel files and found that interview and recruitment processes in line with the relevant policies were not on the personnel files. The files did not display vetting conducted in accordance with the Department of Health circular 1994. Overseas police vetting had not been initiated for two staff who required same.

The centre manager and the deputy manager provided the on-call support for the centre.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**One standard examined**
Practices met the required standard in some respects only	**One standard examined**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The registered proprietor must ensure that they resource the staffing requirements to comply with the Child Care (Standards in Children's Residential Centres) Regulations 1996, Staffing. There must be enough staff who are available, qualified and a balance of experience having regard to the number of young people and the nature of their needs.
- The registered proprietor must review the staff working hours and locations for same to satisfy themselves as to the safety and quality of working hours.
- The centre manager and the operations manager must audit and address the deficits in the vetting and personnel files.
- The centre manager and operations manager must book core training that is outstanding for all staff.
- The centre manager must implement centre based systems for team communication and development and track this through their oversight systems.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The operations manager and proprietor must review and strengthen the admissions policy and procedure to reflect the practices on pre admission risk assessment.	The new operations manager and proprietor met in early Jan 2021 to fully review the admissions process; amending it to include a pre admission risk assessment. The resulting policy shared with Registration on 29th Jan 2021. The risk assessment for the current young person has been completed and signed off and was submitted to registration on 15th Jan 2021.	All policies for Barróg Healthcare will be assessed and a review date provided for updating. In addition, earlier review will take place if required due to learning from incidents. As the admissions policy is used, it will be evaluated to determine the effectiveness and practicality of the process. The Operations Manager will audit the process to ensure that all required steps are taken and that the information gained at referral impacts on the risk assessment and plan for the young person going forward.
	The centre manager must ensure that the required records of preadmissions processes are completed, recorded and filed to a good standard.	The full pre admission actions from the present YP have been included within the file, (checklist sent to Registration 15th Jan	Increased oversight by the CEO and Operations Manager at Barróg Healthcare (increased visits initially every fortnight, then at least monthly) will ensure that

		2021). Barróg Healthcare is currently recruiting to the PIC role; knowledge and experience of residential services and the associated procedures will be a prerequisite for any candidate. The new client management system – Views enables recording of outreach sessions and provides easier scrutiny of records. All staff were trained on the system on 28th Jan 2021 and the system is now live.	records are accurate, timely and of a high standard. Reports will be run from Views that will identify gaps in records, which can then be flagged to a staff member when they log into the system. This will be done at least fortnightly.
	The operations manager and the centre manager must ensure that they audit and oversee all aspects of admissions.	All admissions will be subject to management scrutiny. The operations manager will be aware of all admissions and review the documentation prior to the YP moving in.	An admissions checklist has been created to provide a simple guide to what must be in place at all stages of a YP moving in; this was sent to Registration on 29th Jan 2021.
	The operations manager and the centre manager must establish a clear and cohesive system of needs assessment	This will be addressed through the implementation of the model of care, which is in the process of being	Supervisions will be amended to include discussion on the model to assess staff understanding and use of it. Team

	for young people's placement and implement this in practice.	implemented. Training on the model took place on 3rd Nov 2020 and was facilitated by an external consultant. The model will identify areas of the young person's life to be addressed, prioritised, and inform the placement plan. This process will be subject to ongoing review, and an external consultant has been commissioned to oversee this.	meetings will include discussion of need as well as outcomes for the young person. A contract is in place with the external consultant to provide ongoing support within team meetings. The contract allows for 24 hrs of support per year as well as 8 hours of training across Barróg Healthcare services. Sessions are booked for 9th Feb, 23rd Feb and 23rd March 2021. This model is subject to review each 4 weeks and will inform our Placement plan on a 12-week review period after the Child in Care review with an evaluation. Regular visits from the CEO/Operations Manager will include conversation with staff around the model, in order to check both understanding and implementation. Outcomes from this will be documented through the 'record of visit' form. The YP's placement plan will be updated weekly by keyworkers, overseen by the PIC. All placement plans will be recorded on Views, enabling greater oversight.

	The centres statement of purpose and function must be consistent with the national standards for children's residential centres HIQA, 2018 and with the centres policy on admission.	The new operations manager and proprietor met in early Jan 2021 to fully review the statement of purpose and ensure that it is specific to the services that we offer and ensure it is in line with the national standards. A revised statement of purpose was sent to Registration on 29th Jan 2021.	A new review system will be introduced whereby the management team at Barróg Healthcare formally meets with the Proprietor and Operations Manager at least every six months. The agenda will include review of the statement of purpose; the meetings will be minuted and a copy can be provided to Registration if requested.
	The operations manager and the centre manager must ensure that the training in the proposed model of care be commenced.	The first training on model took place on 3rd Nov. Staff are now using this model in practice and it is discussed within both supervisions and team meetings. The model of care is also now included as an agenda item within supervisions and team meetings. As mentioned above, a contract is in place with the external consultant to provide ongoing support within team meetings. The contract allows for 24 hrs of support per year as well as 8 hours of training across Barróg Healthcare services. Sessions are booked for 9th Feb,	The training log for each staff member is now recorded on our employee recording system. This will enable greater oversight of who has done what training. In addition, since Jan 2021, training is included on the management monthly report, capturing what has taken place (as well as highlighting if training has not been completed). This also allows for shared learning across the organisation as high quality courses undertaken by one team can be recommended to another.

		23rd Feb and 23rd March 2021.	
	The operations manager and the centre manager must review the placement planning process taking account of the stated purpose of the centre, the needs assessment process, timing and review schedules for those placement plans suitable to the needs of the young people.	The current operations manager has formulated an audit document which addresses all aspects of the processes inherent in the centre, and the ongoing effectiveness of the interventions specified in the care/placement plan. This will be utilised going forward with the first full audit completed by 19th Feb 2021. The audit findings will inform the review of the placement planning process. The company is also seeking an external monitor who is suitably qualified, and experienced and with the appropriate clearances for work of this nature. We will continue to seek such a person.	This internal audit will be repeated at six monthly intervals, the findings of which will inform the review meeting between the management team at Barróg Healthcare and the Proprietor and Operations Manager. In addition a 'visit record form' will be used at both announced and unannounced visits by the CEO and Operations Manager. This will highlight discussions with staff as well as audits/checks completed.
	The registered proprietor must take action to audit and assure full compliance with Child Care (Standards in Children's Residential Centres)	Our HR/Health and Safety Company undertook a health and safety assessment at Barróg Healthcare on 6th Nov 2020, finalised on 1st Dec 2020. This included a	Our HR/Health and Safety Company are contracted to undertake health and safety assessments every six months.

	Regulations 1996, Article 13 Fire Precautions. The registered proprietor and operations manager must provide fire training for the staff team.	fire assessment. Training on fire safety was completed for all staff on 8th Oct 2020. Our Fire Safety Company undertook a fire assessment on 30th Sept 2020.	In addition, checks of fire logs will be incorporated into the delegated duties for the Deputy Manager, Team Leader and Shift Leader so that all are clear on their responsibilities. This will be audited through the regular visits by the CEO and Operations Manager and recorded on the visit form.
	The detailed insurance schedule confirming adequate insurance against accidents or injury to children must be provided.	The company is fully insured regarding all aspects of public/professional liability up to an appropriate value.	The insurance is renewed on an annual basis.
	The centre manager must ensure that maintenance and cleaning records are kept up to date at the centre.	Cleaning records are now in place. All cleaning Covid-19 hourly checks are completed by all staff, signed by all staff This will be monitored through regular visits to Barróg Healthcare by the Operations Manager and recorded on the visit form.	This will be monitored through regular visits to Barróg Healthcare by the Operations Manager and recorded on the visit form.
	The centre manager must ensure that a full health and safety audit is completed	Our HR/Health and Safety Company undertook a full health and safety	Our HR/Health and Safety Company are contracted to undertake health and safety

	at the centre.	assessment at Barróg Healthcare which was finalised on 1st Dec 2020	assessments every 6 months. This will be monitored by the HR team within Barróg Healthcare head office
	The centre manager must maintain a copy of the driving licence of all those qualified and insured to drive the centre car.	All staff files have been updated to include driving licences. The HR team within Barróg Healthcare head office have undertaken an audit of all files (Jan 2021) and have contacted staff regarding any gaps in information.	Barróg Healthcare HR team will support the PIC to set up the files of any new staff who join the team, ensuring their driving licence is on file. This will be monitored through regular file audits by the HR team.
	The operations manager and the centre manager must establish a system for the creation, maintenance, oversight and external audit of appropriate records in relation to children.	Views client management system has been brought in as the recording system for all records. Clear forms are now in place which take staff through the information required, copies of these were provided to registration on 29th Jan 2021. A reports module within the system will enable gaps to be identified and resolved. The system has functionality to enable the young person to request their information as well as for information to be shared with Social	The Operations Manager will support the PIC in scrutinising the records for clients. Once the external monitor is in place, they will have access to the system to be able to assess the information recorded. The information can be accessed remotely, so will be checked at least fortnightly by the Operations Manager. In addition, key forms have a section for the Manager and/or Operations Manager to add their

		Workers or Inspectors as appropriate. Training was provided to all staff on 28th Jan 2021 and oversight of this system will be within the remit of the external auditor.	comments.
	The operations manager must formally review through to outcomes and actions the incident related to the removal of the staff file from the centre office.	This incident has been reviewed by the new Operations Manager, alongside a review of GDPR compliance in the service. The report was be provided to registration on 29th Jan 2021. Learning from the incident will be shared with the organisation through the Managers Meetings.	Training will be provided for all staff on GDPR during the first quarter of 2021.
	The centre management must co-ordinate and implement a structured programme for preparation for leaving care in line with the centres stated purpose and function.	At present there is not a structured programme of independent living skills and preparation for leaving care in place. Research will be undertaken in Jan 2021 into programmes such as Pathways to assess their suitability for our client group. This review will include the young person	Once the programme is in place, this will be regularly audited by the Operations Manager to ensure that it is being completed with the young person.

		currently in service and where possible we will liaise with the two young people who have recently transitioned to aftercare to ascertain their views on what they would have found helpful. This review will be completed by 28th Feb 2021 and will include recommendations as to what programme should be implemented.	
5	The registered proprietor and operations manager must implement a robust system for internal and external auditing to ensure oversight of the centre's care practices and operational policies and procedures. Legislation and national policy must be reviewed regularly and identified gaps in compliance must be addressed in a timely manner. The operations manager must ensure that the full policies and procedures development is completed in a timely	An internal audit document has been created and an audit is scheduled. Barróg Healthcare is seeking an external monitor to review all aspects of the operation of the centre. Their report will be presented to the Operations Manager and Proprietor and recommended actions taken forward. Changes in legislation and national policy will be added to the team meeting agenda to ensure that the implications are understood by the team. All policies and procedures are in place and have been shared with the team. Since November 2020 they are now expected to	This process will be scheduled on a 6-monthly basis, with one of the audits being unannounced**.** In addition, regular (initially fortnightly, then at least monthly) visits will be undertaken by the CEO/Operations Manager. A record of these will be kept, noting areas of checks/audits and any required actions. The Operations Manager will work alongside the HR team to devise a schedule for reviewing all policies. In addition,

	manner. A structured programme of team induction should then be conducted.	read and sign at least one policy every shift. Staff induction sessions took place on 3rd Nov 2020.	policies will be incorporated into team meetings, with at least one policy discussed in depth at each meeting. During the regular visits, the Operations Manager will check the records to ensure that staff have signed to say they have read the policies. Any non-compliance will be discussed with the PIC and raised in supervision.
	The centre manager must ensure that there is a record of any formal delegation of management duties and to whom.	A delegation of duties has been created to provide a record of the formal delegation to different people, including the Deputy Manager, Team Leader and Shift Coordinator, this was sent to Registration on 15th Jan 2021. The Deputy Manager and PIC meet at least 1 day per week physically to discuss the overseeing the centre. The PIC and Deputy Manage delegate responsibilities to the team on a daily	

		basis. There are agreed plans and accountabilities in place for the Team Leader and Social Care Workers so all staff are aware of their role and responsibilities on a daily basis.	
	The operations manager and the centre manager must clarify and circulate to all staff the named person who holds the role of designated liaison person, DLP and as deputy designated liaison person, DDLP.	The DLP and the DLLP are both in place; both have completed their training and this information has been shared with staff.	DLP persons are named on the office wall and all staff are aware of named persons. In addition, this is discussed in supervision. The Operations Manager will do an audit of supervisions at least once a quarter, looking at a number of staff files at random. If either of post holders leave, this role will be delegated immediately.
	The registered proprietor must ensure that there are formal arrangements in place to assess the safety and quality of care against the National Standards for Children's Residential Centres, 2018 (HIQA).	The National Standards are on the team meeting agenda, with staff asked to read and prepare examples of the standard prior to the meeting. Minutes of the meetings will be shared with the	Bi - monthly team meetings will discuss National Standards to ensure staff are aware of the standards and know how they impact their work in practice. In addition, supervision and reflective practice will be utilised to discuss concerns, effective or

		Operations Manager for review. This will also be within the remit of the external auditor. Both the Operations Manager and PIC will formally review care standards within the centre on a six-monthly basis. Any shortfall in standards will lead to appropriate action being taken.	ineffective approaches to working with YP as well as how the work undertaken aligns with the standards.
	The registered proprietor and operations manager must ensure that there is specific monitoring and analysing of complaints, concerns and incidents. And that actions and outcomes are implemented in practice.	The new monthly report asks for information on complaints, concerns and significant events. These will be reviewed on a monthly basis by the Operations Manager and Proprietor. Recommendations arising will be communicated to relevant persons and implemented immediately. A log has been created for all complaints, detailing a summary of the situation as well as what learning has come from it and how it has been disseminate. This has been shared with Registration on 5th Feb 2020. The new recording system allows for both PIC and Operations Manager feedback on	Regular supervision sessions with the PIC as well as review meetings will ensure that tasks such as this are completed in a timely fashion. In addition, the monthly report highlights complaints and regular visits to the service and discussions with staff will identify informal complaints that may otherwise be missed.

		incidents/significant events.	
	The centre manager must ensure that up to date and accurate registers for significant events, complaints and admissions and discharges of all young people are maintained.	Logs for complaints, significant events and admissions and discharge are now in place, in the staff office. The new Views system enables SEN's to be easily recorded by staff, reviewed by management and sent for recommendation to Operational Manager, Tusla SEN team and Social Work Department. This is already in place and working well. The Centre has a register of complaint in a folder within the office. Our Complaints Policy stipulates that we have both informal and formal complaints procedures. All information is recorded whether formal or informal to provide evidence based for inspection and family access, YP and all agencies involved in the care of YP.	Ongoing support for the PIC around IT systems as well as discussions about their responsibilities will help to ensure these tasks are completed. Regular review by the Operations Manager and resulting actions will be shared with the team.

	The registered provider must ensure that an annual review of compliance with centre objectives is conducted and that it identifies specific actions to inform service improvement.	This review will be initiated commencing January 2021, and will involve overseeing of reporting procedures, policy and procedures and over all compliance of the standards required for the centre. Any recommendations arising will be acted upon immediately.	Audit in place for the centre will be completed by the Operations Manager on a 6-monthly basis. In addition, regular visits will ensure that issues are identified at an early stage and clear actions given to resolve them.
6	The registered proprietor must ensure that they resource the staffing requirements to comply with the Child Care (Standards in Children's Residential Centres) Regulations 1996, Staffing. There must be enough staff who are available, qualified and a balance of experience having regard to the number of young people and the nature of their needs.	A dedicated staff team is now in place within the centre. All staff will have the requisite qualifications and will be subject to ongoing relevant training. The Centre has 8 fully qualified staff plus PIC. Concerns were raised that there was no Team Leader in post, this has since been resolved and there are now two Team Leaders at Barróg Healthcare. We are aware of the need for staff consistency for our YP. Barróg Healthcare has committed to have 8 fully qualified staff members as per the National Standards. We are working on the	Staff are working a 32-hour week and available to complete up to 39 hours if requested as we only have a single occupancy at present. The Barróg Healthcare HR team are monitoring hours of work to ensure that we are compliant with the Working Time Directive.

		introduction of a policy ensuring that any staff hoping to move from Barróg Healthcare must discuss with the PIC, then provide four weeks written notice which will give us four weeks to employ, induct, and train a new staff member. Throughout the Pandemic, we found it difficult to interview and hire fully qualified staff. We sourced some agency staff, unfortunately, they were not all fully qualified to work under the National Standards. Now that we are aware of this issue, we request a copy of their qualification before they start with us. The company will continue to seek suitable staff to strengthen the staff base and ensure that we have access to an adequate relief panel. Our HR team are working to ensure all records are up to date, including full garda vetting, references and immunisation records. The staff are not required to work over and	

	The registered proprietor must review the staff working hours and locations for same to satisfy themselves as to the safety and quality of working hours.	above their normal working hours-in line with the working time act. This is being monitored by the HR team at Barróg Healthcare.	
	The centre manager and the operations manager must audit and address the deficits in the vetting and personnel files.	All staff have completed Garda vetting and have 3 references checked by head office and PIC. We have requested guidance from the National Vetting Bureau on international checks and will be carrying these out as required.	No staff will be permitted to commence work without all requisite documentation in place. Our processes are being updated to highlight the need for international vetting and all staff where this applies have been contacted.
	The centre manager and operations manager must book the core training that is outstanding for all staff.	All mandatory training is completed by all staff bar one. The outstanding staff member needs to complete training in the behaviour management approach, which as a face-to-face course has been postponed due to Covid-19. First Aid training was due to take place on 10th Nov 2020 but was cancelled due to Covid-19 restrictions; as an interim measure all staff undertook a First Aid	Training records will be held on each staff members BrightHR account, allowing for better oversight.

		Awareness course online on 11th Nov 2020 through our HR/Health and Safety Company.	
	The centre manager must implement centre based systems for team communication and development and track this through their oversight systems.	Management host bi monthly team meetings which are recorded online and in communication files. Going forward, these will be included in the monthly report to allow greater oversight. In addition, the minutes are shared with the Operations Manager. The PIC is present 3 days per week, on any day they are not present the Deputy Manager or Team Leader is present Monday – Friday to support staff. We are recruiting to the PIC role with the aim of having a full time PIC in the service. As Covid 19 restrictions, management communicate with staff zoom including supervision and team meetings and there is a communication book available in the house. The team meeting dates for 2021 have been set and were shared with	Barróg Healthcare is in the process of reviewing internal communications, including regular 'newsletter' type communication. In addition, we will be setting up work email addresses for all staff. Regular visits will ensure that the staff are more aware of the wider company.

		registration on 15th Jan 2021.	