An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 157

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Gateway Organisation Ltd.**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**25th 26th and 27th May 2021**
Registration Status:	**Registered from 17th June 2019 to 17th June 2022 with attached condition.**
Inspection Team:	**Catherine Hanly** **Lorraine Egan**
Date Report Issued:	**17th August, 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 17th June 2019. At the time of this inspection the centre was in its first registration and was in year two of a three-year cycle. The centre was registered without attached conditions from the 17th June 2019 to the 17th June 2022.

This centre originally commenced as a single service and subsequently became part of an already established larger provider of residential care. The centre was registered to provide medium to long term care for up to four young people, male and female, aged between 13 and 17 years of age on admission. The model of care was described as based on an integrated relationship-based approach which provided a framework for positive interventions with young people which meets their social, emotional, behavioural and therapeutic needs. The centre integrated the circle of courage and three pillars model of care in their work with young people. There were four young people living in the centre at the time of the inspection, one of whom was aged 12 and had been placed there via the Tusla Alternative Care Inspection and Monitoring Service derogation process.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.4 only
8: Use of Information	8.1 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. 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

Inspectors consulted with their line management following the completion of the inspection and assessment of findings therein. Following delivery of preliminary findings to centre management, a proposal was made by the inspectors to the Alternative Care Inspection and Monitoring Service (ACIMS) Registration Committee to attach a condition with immediate effect to the centres registration. This proposal was accepted and approved by the Committee on the basis that preliminary findings were that the centre was not operating in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies. Centre management and proprietors were informed on the 1st of June of the decision by the Committee to propose to attach a condition to the centre's registration that there be no further admissions to the centre until the inspection process was completed, the corrective and preventive action plan (CAPA) was implemented and the centre was operating in full compliance with the relevant regulations. The proprietors accepted this decision by the committee.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 28th of June 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The director of services returned the report with a CAPA on the 12th of July 2021. The centre will require time to implement in full the CAPA submitted and included in this report. As such it is the decision of the Child and Family Agency to register this centre, ID Number 157: with an attached condition from the 17th June 2019 to the 17th June 2022 pursuant to Part VIII, Article 61 (6) (a) (I) of the 1991 Child Care Act. The condition attached remains that there be no further admissions to the centre until the CAPA is implemented in full. This decision will be reviewed in February 2022.

3. Inspection Findings

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.

Inspectors reviewed the centre's child safeguarding policy as part of this inspection process and found that the policy required amendment as it was not fully in compliance with the Children First Act 2015 and therefore Children First: National Guidance for the Protection and Welfare of Children 2017. In the area of mandated reporting responsibilities, it was noted to be contrary to the direction detailed within these legislation and guidance documents in that it directed that all concerns be reported in the first instance to the Designated Liaison Person. In addition, the words 'complaint' and 'allegation' were used interchangeably in the centre's policy document and therefore may create confusion for staff referencing this document. Inspectors found that aspects of the child safeguarding policy had not been adhered to in practice at the centre. For example, training in child protection and safeguarding, as identified in the policy, had not been provided for all staff prior to their commencement of employment in the centre. Additionally, not all appointments to specific posts in the centre had occurred in compliance with the policy. The registered provider must take immediate action to address the deficits in policy and practice related to child protection.

The centre had a Child Safeguarding Statement (CSS) which was on display at the centre. The statement identified the centre manager as the Designated Liaison Person (DLP), and the staff team were aware of this, with both deputy managers being identified as deputy DLP's. This statement referred to a list of mandated persons being maintained at the centre however the manager confirmed that such a list was not in fact in place. The centre manager provided inspectors with a copy of the letter of compliance from the Tusla Child Safeguarding Statement Compliance Unit (CSSCU) stating that the CSS was compliant, however this letter did not correspond with the centre's most recently revised CSS which had not been sent to the CSSCU for review. Inspectors noted deficits within the centre's CSS including spelling errors and incorrect acronyms used. Inspectors also observed that the risk assessment included in the centre's CSS should be more detailed and specific in documenting the policies in place to reduce the risk level. Inspectors recommend

that centre management review their CSS and amend as necessary. A list of mandated persons must be created and maintained as specified in the centre's own CSS and the revised CSS should be submitted to the CSSCU for review.

Inspectors found that where concerns of a child protection nature had occurred at the centre, these had been reported appropriately and promptly to the Tusla via the online portal by the centre manager. There were no open child protection reports at the time of this inspection. The centre maintained a child protection and welfare report register for tracking such matters; however, the detail within this record was significantly lacking in that it didn't broadly categorise the event and didn't have corresponding detail related to the Tusla portal entry. This was a matter that had recently been identified by the service's quality assurance audit mechanism and action had been taken to address the deficits through the creation of a new register that allowed for greater detail including cross-referencing the portal reports. Parents were informed of child protection matters that pertained to their child.

Inspectors found there was an anti-bullying policy in place and staff reported that bullying was not an issue at the time of this inspection Staff noted there was limited use of safety plans and risk assessments related to individual young people/events. The policy on bullying must be reviewed and amended to reflect bullying via social media and on the internet. In general, however inspectors found that areas of vulnerability for young people were not readily identified, recorded, discussed or clear management plans in place to address the issues. Inspectors found that staff interviewed could not describe and understand the concept of vulnerabilities as it pertained to the young people in the centre and also they were unable to consistently describe safeguarding practices or procedures or reference the centre's guiding policies on safeguarding. Centre management must take the necessary corrective action to ensure that the staff team have full awareness of their own policy, fully understand safeguarding, their responsibilities in delivering on a safe place for young people and that there is a clear connection between risk assessment, safety plans and equipping young people with the necessary knowledge and skills to keep themselves safe.

There was a whistleblowing policy in place that was brief and clear and that staff were aware of. Inspectors were made aware of a number of issues relating to concerns about staff practice that were not processed in accordance with this policy and had instead been dealt with via investigation conducted on separate matters by the manager in one instance and the quality assurance person in another. Inspectors recommend that additional training and support is provided to the manager to assist

them in managing such matters so that they can be conducted in accordance with centre policy.

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

The centre's policy entitled 'behaviour management and restrictive practice' described numerous tools utilised in the management of behaviour including consequences, team meetings, and placement plans, but did not specifically identify any one approach or a holistic approach encompassing a range of theoretical bases. The policy did not reference the use of role modelling, nor did it refer to the input of the specialists named here of an overarching approach or model to the delivery of care at the centre. These various approaches were evident in records at the centre as having been used. Inspectors received a range of responses from staff regarding the approach to the management of behaviour that challenges. Staff variously referenced role modelling, the use of an identified and approved behaviour management technique, as well as the input from two specialists working for the organisation – an attachment therapist and a clinical psychologist – as guiding the approach to the management of behaviour in the centre.

There were individual crisis management plans (ICMP) for young people although the level of detail in these varied. Safety plans also were inconsistently detailed and some referred back to following the ICMP as opposed to being an additional supporting document in the management of behaviours. There appeared to be a particular emphasis on the direct practice and input from the two specialists, as referenced by management and social workers for the young people, however their specific direction was not consistently evident in planning documents for the young people. Centre management will need to oversee the integration of specialist input with social care practice, through the forum of supervision, team meetings and handovers and with the use of focused reflective practice to deliver an effective and meaningful approach. Inspectors found that there had been no formal review of the centre's approach to managing behaviour that challenges separate to reviews of significant events and the registered provider must ensure that such a review is undertaken, which includes an examination of the policy, and ensure that there is a clear and consistent approach that is evidenced in practice.

The centre's policy on behaviour management and restrictive practice included a definition of a restrictive practice but did not cite examples that may be used at the centre and inspectors found that there was awareness generally amongst the team of

what constituted a restrictive practice. Restrictive practices in use at the time of the inspection included alarms on windows and the use of aerosols for one young person. There was evidence that these were discussed at team meetings. However, there was less evidence of a robust review and analysis of same which must be incorporated into practice.

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

As referenced earlier in this report, inspectors found that although some issues of concern had been raised by individual staff members, differing mechanisms had been instituted in responding to these. Work is required at management level to generate and promote an open culture whereby young people and staff are encouraged to raise concerns and have these appropriately responded to in accordance with clear centre policy.

Centre management had offered social workers and parents the opportunity to provide feedback on the service and one social worker had taken up this opportunity in the past twelve months. The centre manager could not identify any specific change to practice or service improvement that had arisen from this. Inspectors recommend that management review the feedback mechanisms offered to social workers, parents and guardians to ensure they optimise the opportunity for service improvement.

The centre had a policy on significant events that cited examples of events/incidents which were required to be notified; to whom and stating that this should be done as soon as possible after the event. Inspectors noted that incidents were recorded appropriately and reported promptly and all four social workers, with one exception, were satisfied with the content of records and the timeframes within which these were reported to them. One social worker stated that their experience had been to request/pursue information of the centre. Centre management should ensure that all social workers are aware of the centre's policy on reporting incidents and satisfy themselves through their oversight and auditing mechanisms that all relevant information is reported and shared in a prompt timeframe.

The policy on significant events referred to a Significant Event Notification Review Group (SENRG) that would be convened six monthly to review significant events. This review group had been established following the centre's most recent inspection in November 2020 in response to action required to meet the identified standard of practice in this area. Separate to this group, there was evidence of some discussion of

significant events at team meetings however the learning from these and how that informed change or development to practice was not evident. Inspectors reviewed records of the SENRG meetings and noted that these were inconsistent in detail with only some outlining clearly any patterns observed across incidents and learning arising from these that needed to be implemented in practice. Inspectors found limited evidence of connectedness between these reviews and other practice areas including supervision and team meetings, the development of safety or behaviour support plans or alterations to policy and or staff practice. Whilst some reviews acknowledged input from specialists and others referred to the need for review of a child's individual crisis management plan, overall the system lacked an interconnection that would support a more effective care approach. Overall inspectors found limited evidence of shared learning arising from these reviews and the registered provider must take necessary action to satisfy themselves that the system of review of incidents is used to inform the development of best practice and that action is taken with the knowledge of the staff team to improve the care provided in the centre.

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 3.2, 3.3**
Practices did not meet the required standard	**Standard 3.1**

Actions required

- The registered provider must take immediate action to address the deficits in policy and practice related to child protection.
- Centre management must take the necessary corrective action to ensure that the staff team have full awareness of their own policy, fully understand safeguarding, their responsibilities in delivering on a safe place for young people.
- Centre management to review and amend as necessary the centre's Child Safeguarding Statement. This must be submitted for review to the Tusla Child Safeguarding Statement Compliance Unit.
- Centre management to amend anti-bullying policy so that it reflects bullying on social media and the internet.

- Centre management to take corrective action to ensure that the staff team have a thorough understanding of all aspects of practice relating to safeguarding young people which is aligned to their child safeguarding policy. This should be refreshed regularly.
- The registered proprietor must undertake a review of the approach to the management of behaviour that challenges and in doing so, ensure that there is a clearly understood and consistently delivered on approach by the staff team.
- Centre management must oversee a robust review and analysis of the use of restrictive practices at the centre.
- Centre management must institute mechanisms and practices that promote an open culture whereby staff and young people are encouraged to express concerns.
- The registered provider must take necessary action to satisfy themselves that the system of review of incidents is used to inform the development of best practice and that action is taken with the knowledge of the staff team to improve the care provided in the centre.

Regulation 5: Care Practices and Operational Policies
Regulation 6: 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 limited evidence to demonstrate that the quality, safety and continuity of care provided to the children in this centre was being regularly reviewed in a manner that led to informed improvements in practice and was aimed at achieving better outcomes for young people placed in the centre. Whilst there had been one discharge of a young person, who had moved on successfully to an identified placement, there was no evidence of any learning from this placement having been implemented in policy or practice at the centre. A second young person was discharged from the centre in a planned manner the week of this inspection. There was no evidence of formal reviews of policies, practices or systems to ascertain their effect on placements for young people or to assess the general delivery of care at the centre. Centre management and staff were unable to confidently report on the work that had been completed with them throughout the course of their placement

that had addressed the reasons for their coming to reside in the centre and concluding with their return home. The manager and staff team could not demonstrate through interview their familiarity with the concept of the provision of quality and safe care and could not easily demonstrate how systems, policies or practices in place at the centre informed improvements or achieved better outcomes for young people. Centre management must satisfy themselves that this requirement is successfully achieved and understood by all working in the centre.

In November 2020 centre management had implemented a system of auditing of centre policy and practice against the National Standards for Children's Residential Centres and appointed a quality assurance coordinator. This person was tasked with the responsibility of developing and strengthening the framework for internal governance within the organisation and to embed the governance structures throughout the organisation. A schedule of audits had been created and a dedicated quality assurance coordinator had completed three separate audits covering six separate themes at the time of this inspection. The audits were conducted in a collaborative way with the centre manager, service director and quality assurance coordinator. Two of these audits, comprising four separate themes, had been completed the week prior to this inspection, six months after the quality assurance coordinators appointment to post. The implementation of the findings of these audits, which were minimal, was in its infancy and could not be fully assessed during this inspection. Some recommendations/actions had not been realised in practice at the time of this inspection, for example an action had been identified to review restrictive practices through discussion at team meetings. Inspectors noted that the deficits identified during this inspection for example relating to the child protection policy and referenced earlier in this report, had not been identified by the services own audit. Inspectors recommend that a methodology be included in the audit reports to demonstrate what information gathering processes informed the findings detailed therein. The actions sometimes lacked specificity as to what change/improvement was required to be made in order to ensure full compliance. Inspectors recommend that modifications are made to the auditing report and system to include more detail as well as a checking system for the quality assurance coordinator and service director so that they are satisfied identified actions have been fully implemented.

As noted earlier in this report whilst there was some evidence of reviews of incidents at team meetings, with monitoring and analysis documented at the significant event review group forum, overall the evidence of learning from these events coupled with generating improvements in practice was significantly lacking. The registered

provider must take the necessary action to satisfy themselves that information generated through concerns, complaints and incidents is recorded and utilised in a manner that ensures learning is clearly communicated with all relevant persons and that it is utilised to promote improvements at the centre.

An annual review of compliance had been completed although the author of this was not identified on the report. The report was clear and comprehensive with timeframes included for the implementation of changes necessary.

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

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

Actions required

- Centre management must implement the necessary mechanisms to provide assurances that there are regular and informed reviews of the quality of care provided at this centre. These should be clearly understood by the management and staff team.
- Centre management to modify the auditing report and system to include more detail as well as a checking system for the quality assurance coordinator and service director so that they are satisfied identified actions have been fully implemented.
- The registered provider must take the necessary action to satisfy themselves that information generated through concerns, complaints and incidents is recorded and utilised in a manner that ensures learning is clearly communicated with all relevant persons and that it is utilised to promote improvements at the centre.

Regulation 17: Records

Theme 8: Use of Information

Standard 8.1 – Information is used to plan, manage and deliver child-centred, safe and effective care and support.

Inspectors found that there were systems in place for the collation and management of information gathered. These included daily reports for young people, significant event reports, progress reports, and various plans that pertained to their daily care such as placement, safety and crisis management. Information was shared with supervising social workers on a regular basis for the purpose of informing decision-making on a day to day basis as well as on a medium to longer term basis at statutory care plan review meetings for example. Inspectors found, as has been documented elsewhere in this report that improvements were necessary in the centre's system of information gathering and usage to adequately evaluate the quality of the service provided. Whilst information was gathered and some learning was evident, inspectors found that a more interconnected approach to the use of information must be implemented to satisfy the demonstration of good quality care in this centre.

Information on young people was gathered throughout the duration of their placement at the centre. Aspects of this was reviewed in various mechanism including team meetings, daily handovers and through the generation of progress reports. Inspectors found that the focus of the information gathering could be more evidently aligned to purposeful placements such as including identification of risk and associated supports for young people.

The centre manager confirmed that parents and young people were informed about the recording and usage of personal information. Detail about this was also included in the young person's information booklet on the centre.

Compliance with Regulation	
Regulation met	**Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified, not all standards examined**

Practices met the required standard in some respects only	**Standard 8.1**
Practices did not meet the required standard	**None identified, not all standards examined**

Actions required

- Centre management must implement a more interconnected approach to the use of information to satisfy the demonstration of good quality care in this centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies to Ensure Issues Do Not Arise Again
3	The registered provider must take immediate action to address the deficits in policy and practice related to child protection.	Immediate work to address deficits in practice was undertaken by the centre manager with the staff team on the 2nd of June. The vulnerabilities and risk of the residents were examined as well as appropriate measures to ensure safety. Child safeguarding statement and practice including the role of mandated persons, linking theory to practice and the Approach to Care were addressed with the staff team. In addition to this, the centre manager gave all staff documentation to read on the areas of child protection, consistency of practice and attachment theory and examined staff's knowledge of this material by means of quiz and discussion on the 14th June and, as appropriate, whilst staff are working shifts. The deficits identified in the child	Policy related to child protection will be reviewed annually to ensure ongoing compliance with legislation and regulation. The centre manager will also ensure these policies and procedures are routinely discussed at team meeting and in supervision. Regular audits will assess practice and staff understanding of policies in relation to child protection. Audits will be conducted by the QA coordinator with the assistance of the centre manager, senior manager and director of services. (Next audit scheduled for the 10th August in house.) Please see Theme 5 for reviewed organisational chart. This role, will provide additional support for the centre manager, As per details in Theme 5, a review of the

		safeguarding policy in relation to reporting of incidents and use of the terms complaints and allegations have been corrected. In addition to this, the director of service will complete a more extensive review of the policy to ensure it is in line with relevant legislation, national policy, and national standards by August 2021. A training needs analysis on the deficits in practice has been completed and a training schedule to address these deficits has been developed. Further immediate work was undertaken by an attachment specialist, to assess consistency of practice during training on the 10th and 11th June. Eleven staff (one staff member has resigned) have undertaken refresher training in Children's First by completing the online course provided by Tusla. All staff have been provided with copies of the child safeguarding policy and statement for review.	audit process is being undertaken with the assistance of an external provider. The revised process will ensure review and identification of key areas and development of key performance indicators to assess ongoing compliance with regulation and standards. The revised process will include an escalation process for findings and a follow up mechanism for corrective actions that are identified. The senior manager and QA coordinator will attend team meetings on a bimonthly basis to share the findings and discuss corrective actions.

	Centre management must take the necessary corrective action to ensure that the staff team have full awareness of their own policy, fully understand safeguarding, their responsibilities in delivering on a safe place for young people.	At the team meeting scheduled for the 14th July, the centre manager, and QA coordinator will facilitate an in-depth discussion on Child Protection, Child Safeguarding Statement and Child Safeguarding Policy. All staff will complete the full child protection training. The centre manager has amended the staff supervision templates to include discussions on child protection policies.	The requirement for all staff to complete Children's First Training as part of their pre commencement induction will be strictly adhered to and monitored via the induction checklist. Staff will receive regular updates on child protection policies including annual refresher training when the policy and safeguarding statement is reviewed. The centre manager will audit the staffs' knowledge of policies by way of supervision, discussion at team meetings and attendance at handover meetings. The QA coordinator will assess staff knowledge on safeguarding via the audit schedule and provide feedback and corrective action on the findings. The QA coordinator and senior manager will attend team meetings on a bimonthly basis to provide this feedback.
	Centre management to review and amend as necessary the centre's Child Safeguarding Statement. This must be submitted for review to the Tusla Child	The centre manager has reviewed the Child Safeguarding Statement in consultation with director of services and Quality Assurance coordinator to include	The centre manager will ensure that the Child Safeguarding Statement is reviewed annually, in consultation with Senior Management, and is submitted to Tusla

	Safeguarding Statement Compliance Unit.	more specific policies which address the reduction of risk. The Child Safeguarding Statement has been submitted for Review to Tusla Child Safeguarding Compliance Unit on 6th July 2021. The centre manager has compiled a list of mandated persons in the centre. This list is available with the Child Safeguarding Statement.	Child Safeguarding Statement Compliance Unit each time it is updated or at the scheduled submission frequency. The Child Safeguarding Statement will be discussed with staff via team meetings and supervision.
	Centre management to amend anti-bullying policy so that it reflects bullying on social media and the internet.	The anti-bullying policy has been revised, to reflect cyberbullying. The centre manager will discuss this policy with staff at the team meeting on July 14th.	The anti-bullying policy will be reviewed on an annual basis to ensure it is in line with regulation and standards and reflects all relevant risks.
	Centre management to take corrective action to ensure that the staff team have a thorough understanding of all aspects of practice relating to safeguarding young people which is aligned to their child safeguarding policy. This should be refreshed regularly.	The centre manager and QA coordinator will facilitate an in-depth discussion with the full staff team on the Child Safeguarding Policy at the staff meeting on the 14th of July. This discussion will focus on the practical application of the policy in relation to practice. The centre manager will have an in-depth discussion with each staff member in their supervision to ensure that each staff member has a thorough understanding of	The QA coordinator will include implementation of this policy in the audit schedule with appropriate feedback and corrective action based on findings. The QA coordinator will include practice in relation to protection and safeguarding in the audit schedule. Feedback and corrective actions from these audits will be discussed at team meetings with the QA coordinator and senior manager in attendance.

		all aspects of practise relating to safeguarding young people which is aligned to their safeguarding statement. As stated above the supervision template has been amended to facilitate this discussion. Eleven staff have completed Introduction to Children's First and all will complete the full Children's First two-day course.	
	The registered proprietor must undertake a review of the approach to the management of behaviour that challenges and in doing so, ensure that there is a clearly understood and consistently delivered on approach by the staff team.	The director of services and QA co-ordinator will complete a review of the behaviour management policy to ensure it provides clear direction in terms of the overarching approach to include attachment and trauma-based theories. The policy will also include the use of role modelling and the review will be completed by August 21. To support this review training on the key elements of the approach is being undertaken. The consultant attachment specialist, completed a 2-day practice review and attachment and consistency training with the staff team on the 10th and 11th of June	The centre manager will participate in the therapeutic team of the wider organisation as part of the reorganisation of services The therapeutic team involves bi-monthly meetings attended by the organisation's psychologist and childcare consultant to ensure the approach staff are using to manage behaviour that challenges are cohesive and consistent. The centre manager will ensure that regular attachment training is scheduled every month and that this is discussed at team meetings. The QA coordinator will review behaviour management as part of the audit schedule. The QA coordinator and the senior

		2021. Further training will be provided on this topic and TCI, including the TCI module on Post Crisis Response.	manager will attend team meetings on a bimonthly basis to provide audit feedback and discuss corrective actions.
	Centre management must oversee a robust review and analysis of the use of restrictive practices at the centre.	The centre manager will complete a review of the restrictive practice policy by August 2021 with the assistance of the QA coordinator. Following this the keyworker and centre manager will review any restrictive practices in place for each child including a risk assessment of each practice. The centre manager and key workers will bring the updated restrictive practices and risk assessments to the team meeting for discussion. Restrictive practices will be reviewed on a monthly basis in line with ICMP or more frequently as a result of a specific event. Young people in the centre will be made aware of and helped to understand the reason for any restrictive practices being applied.	Restrictive practices will remain on the staff team meetings as a standing item on the agenda and decisions will be reflected in the minutes. Discussion will also occur in supervision sessions. Restrictive practices will be considered at pre-admission and included on the young person's placement plan. The QA coordinator will review restrictive practices as part of the audit schedule. The QA coordinator and senior manager will attend the team meeting on a bimonthly basis to provide feedback from audit findings and discuss corrective actions.
	Centre management must institute	The director of services will address the	The director of services and centre

	mechanisms and practices that promote an open culture whereby staff and young people are encouraged to express concerns.	staff team to communicate to them the need to 'stay curious and question everything'. This talk encompasses the importance of staff exercising their professional judgement. On the 14th July, the centre manager and QA coordinator will remind staff that there is an open-door ethos for the staff in the centre to approach the manager with any concerns. The centre will continue to hold house meetings with the young people which includes concerns and complaints. The minutes of these meetings will continue to be discussed at team meetings. The centre will continue to welcome informal daily issues from the young people, and these are managed appropriately. A suggestions box for young people to highlight changes they wish to seek within the centre and identify any issues arising or them was put in place on the 8th July.	manager will work towards the award of Investing in Children for the centre to promote the voice of the child within the Centre, commencing 12/7/2021. Concerns and open culture will be a standing agenda item during supervision. Training in reflective practice is scheduled for the 16th September.
	The registered provider must take necessary action to satisfy themselves	External assistance has been sought on a number of areas of practice in relation to	Further work will be completed with an external company during July and August

	that the system of review of incidents is used to inform the development of best practice and that action is taken with the knowledge of the staff team to improve the care provided in the centre.	the quality systems in the centre including the management of incidents. The external company attended on site for an initial 2 days on the 5th and 6th of July to conduct a baseline review. As a result of this review the following measures have been implemented. An Incident tracker tool has been developed to better record incidents. All Significant incidents will be escalated to the senior manager for review. All significant incidents will be discussed at the wider management meeting which the centre manager will attend. Key findings and trends from incidents will be discussed at the team meeting.	on incident reporting to include. • Revision of the Significant Event Policy; • Development of a robust system of tracking and trending of incidents; • Training for managers and staff on the quality system to develop and implement corrective actions. A set of KPIs for circulation to all stakeholders including Staff, Centre Management, Senior Manager, and the Board will be developed.
5	Centre management must implement the necessary mechanisms to provide assurances that there are regular and informed reviews of the quality of care provided at this centre. These should be clearly understood by the management and staff team.	The centre manager and director of services have increased the frequency of feedback from the young person, family, and professionals to four months to gain more up to date information. The centre manager has reduced the timeframe of placement planning from six months to three months to allow the staff team to evaluate short term goals, long	Each young person will have the organisation's bespoke psychological tool, Access Integrated Clinical Programme (AICP) completed annually by the Clinical Psychologist which enables the evaluation of the young person progress across a range of development and social domains whilst also informing the care of the young person.

		term goals and quality of care each young people is receiving. This will be carried out in team meetings and discussed at supervision. Reflective practice will be broadened in daily handovers and supervision to reflect the quality of care. This will include identifying risks and vulnerabilities for young people.	The therapeutic group that meets on a bimonthly basis will review care provided to young people and make recommendation on same. The centre manager will attend these meetings and provide feedback to staff on outcomes and recommendations. The centre manager in consultation with the senior manager for residential services and QA coordinator will review each young people's placement after their discharge and implement learning outcomes with the team, this process will commence in July 2021.
	Centre management to modify the auditing report and system to include more detail as well as a checking system for the quality assurance coordinator and service director so that they are satisfied identified actions have been fully implemented.	As part of the new governance arrangements referred to in the general information an external agency has been engaged to complete a quality governance review of this centre as part of the wider group.	The full recommendations from the external consultancy review will be implemented in relation to audit practices to include: Comprehensive audits which assess practice and knowledge in line with regulation and standards; Escalation and communication methods for audit findings to include feedback to staff groups; Development of KPIs based on audit,

			incident, complaint and concern trends and findings for review by senior management and the board subcommittee. A process for tracking and monitoring close out actions recommended in reviews
	The registered provider must take the necessary action to satisfy themselves that information generated through concerns, complaints and incidents is recorded and utilised in a manner that ensures learning is clearly communicated with all relevant persons and that it is utilised to promote improvements at the centre.	By the end of August the external agency are all scheduled to complete the following work: Recommended the quality governance structure for the centre as part of the Organisation group Revised the audit process; and completed a baseline audit versus all 8 themes of the national standards; Revised the incident, complaints and concerns reporting process; Provided training to all staff on the new processes.	
8	Centre management must implement a more interconnected approach to the use of information to satisfy the demonstration of good quality care in this centre.	The centre manager will ensure that training sessions from the Attachment Specialist and Clinical Psychologist is utilised in daily work with the young people and is included in safety plans, ICMPs, placement plans and behaviour management policy.	The centre manager will oversee the recording of information & satisfy themselves that the young person is receiving good quality of care as per guidance from Attachment Specialist and Clinical Psychologist.