Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 163

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Tus Nua Childcare Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**8th, 9th and 10th June 2021**
Registration Status:	**Registered from the 24th of October 2019 to the 24th of October 2022**
Inspection Team:	**Cora Kelly** **Lorraine Egan**
Date Report Issued:	**26th October 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 in October 2019. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from 24th of October 2019 to the 24th of October 2022.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was described as the secure base model which has its roots in attachment theory and resilience. There were four young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3

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 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 abouthow 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, centre manager and to the relevant social work departments on the 22nd of June 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 12th of July 2021. The inspectors requested a further review of the CAPA to be undertaken with an agreed CAPA finalised on 13th October 2021. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be 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: 163 with an attached condition from the 15th June 2021 to the 28th February 2022 pursuant to Part VIII, 1991 Child Care Act. The condition being:

There will be no further admissions to the centre until such time that the centre is fully compliant with Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 5 *Care Practices and Operational Policies*, that appropriate and suitable care practices and operational policies are in place, having regard to the number of children residing in the centre and the nature of their needs.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
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.

Over the course of the inspection the inspectors found from the review of all information gathered relating to child protection and safeguarding that there were significant deficits in safeguarding practices being implemented within the centre and consequently, the centre was not operating in compliance with the relevant policies as outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015. These safeguarding deficits were not being identified by centre management or by the governance systems in place. These will be highlighted throughout this report. The centre's child protection and welfare policy and procedures were contained in two separate documents: the operational policies and procedures document and a separate child protection and welfare policies and procedures document. Procedures for protected disclosures, reporting concerns, code of behaviour between staff and children, anti-bullying, safe recruitment and selection and lone working were contained in the policy documents. However, deficits were found in the policies regarding:

1. How to recognise child abuse
2. An absence of correct procedures for reporting child protection and welfare concerns
3. Adequate procedures to follow in the anti-bullying policy and the complaints policy.

The centre did not have a policy on electronic communication that included procedures for responding to and managing possible exploitation on the internet and social media.

The inspectors were advised that the child protection training provided to the staff team was based on the centres own document. From interviews conducted and the review of documentation it was evident to the inspectors that safeguarding practices aimed at protecting and promoting the care and welfare of young people required immediate significant improvement. The inspectors found that management and the

staff team demonstrated a limited understanding and knowledge base of the centres own safeguarding policies and procedures or national policies. This was found from interviews and questionnaires where staff were not able to name safeguarding policies guiding their work. In addition, the inspectors identified a number of child protection concerns that should have been reported to Tusla as mandated reporting. Child protection was not a standing topic at the team meetings and from the review of team meeting minutes there was no record of child protection related areas or issues being discussed. It was an agenda item at management meeting minutes. However, it was found that for one management meeting where an allegation against a staff member was named there was no record of any discussion that took place. The inspectors observed from the review of centre paperwork this allegation was recorded as a complaint in the complaints register. The inspectors did not observe that the external auditor had identified this allegation/ complaint during their audit of practices.

The centre manager advised the inspectors in interview that they were the appointed designated liaison person for the centre and had been provided with relevant designated liaison person training. There was also a deputy designated liaison person, but they had yet to complete the training. This was scheduled to take place following the inspection. The child protection policy did not name the centre manager as the designated liaison person, nor did it name the deputy designated liaison. From the review of questionnaires and interviews not all members of the staff in interview knew who the appointed designated liaison persons for the centre were. All members of the staff team had been provided with child protection training and had completed the Tusla E-Learning module: Introduction to Children First. The inspectors observed related training certificates during their review of a sample of individual staff personnel files. Modules completed as part the child protection training included legislation, national guidance and the centres policy and procedure, types of abuse and how they may be recognised, reporting procedure for child protection and welfare concerns, record keeping and procedures for responding to allegations of abuse against workers. The inspectors found that staff were unable to relate what they had completed in training to practice in the centre.

There was a child safeguarding statement in place and a letter of compliance from the Tusla Child Safeguarding Statement Compliance Unit was observed by the inspectors. The statement was not displayed publicly in the centre as required and not all members of the staff team had signed it indicating that they had read and understood the statement. It was stated in the policy that all staff members were deemed mandated persons. From the review of relevant paperwork, the inspectors found that

members of the staff team did not meet the required criteria. To ensure compliance with the Children First Act, 2015 the director of service, named as the relevant person in the child safeguarding statement must identify those members of staff who have mandated responsibilities and ensure that the statement is publicly displayed in the centre.

The centre manager reported that no child protection and welfare concerns had been reported to Tusla through the online portal system since the centre opened in October 2019. However, as mentioned above the inspectors identified concerns that should have been reported through the online portal system. Further to this, the inspectors found that deficits existed regarding senior and centre management practices in complying with a procedure contained within the centre's anti-bullying policy. It was outlined in the centres anti-bullying policy that if a young person was at risk from a peer, it would be escalated to senior management and be classified as a child protection and welfare concern. The inspectors had identified that for three young people bullying behaviour incidents had not been escalated and reported as child protection and welfare concerns under the policy. This deficit in practice also demonstrated the lack of understanding regarding administering their mandated responsibilities. Further, in some instances, the complaints procedure was followed when addressing incidents of bullying behaviour. It was clear to the inspectors that the complaints process was an ineffective way to respond to the repeated incidents of bullying as it brought about no changes and young peopleremained at harm from peers. The director of service must update the anti-bullying policy to ensure that there are appropriate procedures in place that ensure that bullying behaviour is managed to prevent harm to young people.

In addition to this, the procedures for reporting child protection and welfare concerns were not clear for those with and without mandated responsibilities. A staff member, who held mandated responsibilities, stated in interview that a child protection and welfare concern that had been raised to them was passed on to the designated liaison person for them to manage. They did not know the outcome of the concern. The inspectors did not observe a record of this concern on the young person's care file. This reporting procedure and management of the concern was not in line with legislation and good safeguarding practices. The director of service must review and update the child protection and welfare policy document immediately to address the deficits outlined in this report, provide staff with refresher child protection training and satisfy themselves that all staff fully understand the practice of safeguarding and adherence to Children First guidelines.

The centre had governance processes in place to capture practices and data relating to child safeguarding. Internal governance processes in place included the centre manager completing monthly reports and the director of service completing bi-monthly audits based on the information recorded in the monthly report. Whilst there was some information recorded in these reports there was no robust analysis of data returned. External processes included an external auditor conducting three monthly audits and monthly significant review group meetings. It was clear to the inspectors that adequate oversight of the child safeguarding practices in operation was not in place. The director of service must strengthen centre and senior management and governance systems to ensure that they are robust in identifying and managing child protection and welfare concerns and monitoring safeguarding practices.

The centre had a risk management framework in place. However, upon review of the processes in place to identify, assess and manage risks the inspectors could not get a clear determination of how the framework operated in practice and if it was effective. In terms of risk identification, the lack of a pre-admission risk assessment tool was preventing the centre from establishing clear indicators of risk presented by a young person prior to being admitted to the centre and how they would then be managed through safe strategies and interventions. The risk matrix system used to assess risk levels was not being utilised appropriately. It was found that there was very little modification to risk ratings when internal and external control measures were identified. Further, the same control measures were recorded by the centre in managing the various presenting behaviours. It was found from the review of four impact risk assessment forms that the section relating to consultation with professionals, social workers and guardian ad litums was not utilised and social workers had not signed the documents. The director of service must review the risk management framework to ensure that effective processes are in place that identify, assess and manage risks and that it includes pre- admission risk assessment processes. Centre management and staff should work collaboratively to promote the safety and wellbeing of children.

Inspectors found there was limited evidence that young people were being supported to develop the knowledge, self-awareness and understanding of how to protect themselves and to talk to staff about their fears. Through a questionnaire a young person reported that they did not feel safe in the centre. For another young person it was recorded in their file that they were scared and on another occasion that they didn't want to be on their own. When a young person did disclose to staff appropriate child protection procedures were not followed. It was observed that while

some key working around helping young people develop self-care and protection skills was taking place specific resources were not utilised and there was little engagement by the young people during these sessions. The inspectors did not observe work being completed in the areas of consent, safety inside and outside the centre, sex education or social media which had presented as an issue in the centre for two of the young people. These areas were not comprehensively included in the young people's placement plans and lacked any clinical input despite the young people having diagnoses relating to mental health. Senior management must ensure that a more robust key working system is developed that ensures comprehensive programmes and plans that support young people in developing skills for self-care, self-awareness, understanding and protection are developed, that it improves engagement between keyworkers and young people and includes clinical support.

The inspectors found the staff were not consistently identifying and responding to the young people's areas of vulnerability. For one young person a guardian ad litum requested a strategy meeting to discuss issues that the young person they were appointed to were experiencing. A second strategy meeting was requested by a young person's social worker due to concerns they held about ongoing issues in the centre. Safety measures applied following this meeting included safety plans being developed for all young people in the centre with a fourth staff member being available to support the staff team on an on-call basis. From interviews and questionnaires staff were not aware if the safety plans were actively in place or not at the time of the inspection despite the risk behaviours remaining in the centre.

In interview and from the review of questionnaires staff did not identify the protected disclosures policy if they were to address poor practice. The centre manager must review the protected disclosures policy with the staff team immediately.

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

The centre had policies and procedures for managing behaviour that challenged, practices following physical intervention, positive behaviour support, consequences and restrictive practice. A specific policy and procedure for restrictive practices had not been developed. From interviews and the review of questionnaires there was limited staff knowledge regarding the centre policies, procedures and practices that looked at managing behaviour. Processes for managing and responding challenging behaviour required significant improvement.

Staff were being provided with training in a recognised model of behaviour management and for those eleven who had completed full training they had up-to-date refresher training. Deficits in this training included the three newest remembers of staff who had yet to complete this core training piece. The centre did not have a register to record physical intervention that had occurred. Physical interventions that had occurred for two young people were entered in the significant events register. The inspectors found that for one physical intervention that lasted a twelve minutes it was not reviewed effectively through the centres internal review mechanism or at the centres significant event review group (SERG) meeting. The inspectors found that no learning was shared with the staff team from this event during their review of centre documentation and young people's files. The director of service must ensure that processes aimed at managing challenging behaviour are reviewed and strengthened immediately and that management and staff are clear of these following the review process.

From the review of records in the centre including notifications of significant events bullying behaviour by young people was on-going in the centre. It was evident that strategies and plans put in place by the centre were not effective in reducing it. It must be firstly recognised by the staff team and management as bullying and then all attempts made to reduce the behaviour through researched tools and programmes are required for responding to the serious bullying and challenging behaviour overall and mitigating this behaviour. This would involve discussions with social workers and where it cannot be effectively managed and stopped then decisions need to be made about whether staff can provide safe care to all of the young people. The director of service must develop and oversee the implementation of an anti-bullying strategy aimed at mitigating the levels of bullying behaviour presenting in the centre.

As part of the behaviour management programme that staff were trained in and in line policy it was stated that life space interviews would be completed with young people following any incident to help them understand their behaviour. Inspectors found that whilst staff made themselves available to young people to conduct these interviews there was little engagement by the young people. The director of service must review at the SERG meetings, how life space interviews are conducted and look at ways to encourage young people to engage in the process.

Staff in the centre were provided with various plans that supported young people and their behaviours. However, deficits were found regarding the structure of the various individual plans in place and how they were being communicated to the staff team. All four young people in placement had individual crisis support plans (ICSP's) that

were regularly reviewed to reflect changes in behaviours. However, the inspectors found that the interventions identified to manage behaviours were not robust and lacked input by the clinical psychologist that was available to support the staff team. These plans were not signed by the young people's social workers. The centre manager must review all ICSP's to ensure that clear and specific interventions to manage risk behaviours are stated. Individual absent management plans (IAMP's) were on file for all young people. The inspectors found that for two young people they had not been updated to reflect free time that had been sanctioned by their social workers. The centre manager must ensure that all IAMPS' are up to date. Behaviour support plans were held for each of the young people. Upon review, the inspectors found that were essentially daily and nightly routine plans as they didn't address young people's behaviours or outline agreed strategies or other interventions to manage behaviours. The inspectors found from the review of team meeting minutes that no discussions on the individual plans in place for young people were recorded. The centre manager must review the purpose and function of behaviour support plans and ensure that all individual plans in place for young people are routinely discussed at staff team meetings to ensure that they are having an impact on the behaviour and that they young people are progressing in their placements.

The centre had developed an auditing tool since the Alternative Care Inspection and Monitoring Service, (ACIMS) last inspection in July 2020. For the purposes of theme 3 the format of the existing auditing tool was not aligned to the criteria relating to 3.2 or that of 3.1 and 3.3. Therefore, a clear view of staff practices and young people's experiences was not being captured. The director of service, as the registered provider, must review the auditing system to ensure that practices aimed at monitoring the residential centre's approach to managing behaviour that challenges are in place.

The centre did not have a policy on restrictive practices as required under the National Standards for Children's Residential Centre (HIQA) 2018. From interviews and the review of questionnaires there was on overall lack of knowledge on what constituted a restrictive practice despite several restrictive practices being utilised in the centre. The consequences of restrictive practices remaining in place included for example a lack of freedom of choice for one young person. The director of service must develop without delay a policy and procedures on restrictive practicesthat complies with criteria 3.2.6, 3.2.7 and 3.2.8 of the HIQA Standards, 2018.

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

The inspectors found that centres process whereby young people and staff could raise concerns and report incidents required significant improvement from a policy, practice and governance perspective. The policy and procedures on complaints was inappropriately used as a procedure for responding to incidents of bullying and allegations against the centre manager and staff were deemed as complaints.

A total of eight complaints had been recorded in the centre's complaints register sincethe last inspection of the centre in July 2020. Although not indicated in the register it was found from the review of complaints records that all were found to have been formal complaints. Several observations were found from the review of the complaints register; all were recorded as being concluded, not all were entered into the centre significant event notification register as per centre policy, all were managed internally by the centre manager and none of the complaints reached stage 3 'external investigation' procedure for managing complaints. The inspectors identified that four of the entries did not constitute complaints and should have been managed as per reporting guidelines outlined in the centres child protection policy. Social workers in interview were aware of the complaints and were satisfied at the way they were managed by the centre. In a questionnaire a young person indicated that complaints are not taken seriously. The inspectors concur with this finding due to the continuing bullying behaviour within the centre and the failure of staff and management to recognise and report incidents as child protection and welfare concerns. There was no evidence of complaints having been discussed at the young people's meetings or during team meetings. The inspectors did not see any evidence that suggested complaints were monitored to identify trends and patterns and areas for improvement. The director of service must conduct a full review of the complaints system and ensure all findings in this report are included in the review.

The centre did not have a mechanism in place to gather feedback from significant people in children's lives aimed at identifying areas for improvement. The director of service must develop a feedback template to gather opinions from parents and social workers on the provision of care being provided to young people and that it informs service improvement.

There was a significant events policy and a separate significant review group policy. The inspectors found that significant event incidents (SEN's) were reported promptly

by the centre manager to the relevant professionals including the clinical psychologist in agreement with the social workers appointed to all the young people. The centre manager held responsibility for reviewing each SEN and providing their comment on the SEN record. This was observed across SEN's reviewed by the inspectors. SEN's were not discussed during team meetings or at management meetings. The number and types of SEN's were included in the monthly report completed by the centre manager and forwarded to the director of service.

Despite reporting and internal review processes in place the inspectors found clear evidence that the SEN's were not being recorded in full or accurately in order to determine staff practices, whilst other incidents were not escalated as child protection and welfare concerns and there was no indication in most cases when physical intervention had been deployed. It did not appear that managerial comment had led to any change in staff practices. Externally, SEN's that reached a threshold were automatically reviewed at the monthly SERG meetings that included attendance by the clinical psychologist, however staff members were not part of this group. Upon review of these meeting minutes the inspectors observed that the template was not being used in full, there was limited data recorded that indicated that there was learning from SEN's reviewed. Staff in interview couldn't identify specific learning from the SEN's either. Through the review systems in place internally and externally there was no evidence of SEN's being analysed and of clinical advice being recorded. Overall, review mechanisms are not being used to their full potential and the inspectors were not able to determine if learning that focused on outcomes that informed future practices occurred. The director of service must review the processes for recording and reviewing incidents, that staff are part of the review process and ensure that learning is effectively communicated back to the staff team.

Compliance with Regulation	
Regulation not met **Regulation not met**	**Regulation 5** **Regulation 16**

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

Actions required

- The director of service, named as the relevant person in the child safeguarding statement must identify the members of staff who have mandated responsibilities, that all staff read and sign the child safeguarding statement and ensure that the statement is publicly displayed in the centre.
- The director of service must update the anti-bullying policy to ensure that there are appropriate procedures in place that ensure bullying behaviour is managed to prevent harm to young people.
- The director of service must review and update the child protection and welfare policy document immediately to address the deficits outlined in this report, provide staff with refresher child protection training and satisfy themselves that all staff fully understand the practice of safeguarding and adherence to Children First guidelines.
- The director of service must strengthen centre and senior management and governance systems to ensure that they are robust in identifying and managing child protection and welfare concerns and monitoring safeguarding practices.
- The director of service must review the risk management framework to ensure that effective processes are in place that identify, assess and manage risks and that it includes preadmission risk assessment processes and centre management, and staff should work collaboratively to promote the safety and wellbeing of children.
- Senior management must ensure that a more robust key working system is developed that ensures comprehensive programmes and plans that support young people in developing skills for self-care, self-awareness, understanding and protection are developed, that it improves engagement between keyworkers and young people and includes clinical support.
- The centre manager must review the protected disclosures policy with the staff team immediately.
- The director of service must ensure that processes aimed at managing challenging behaviour are reviewed and strengthened immediately and that management and staff are clear of these following the review process.
- The director of service must develop and oversee the implementation of an anti-bullying strategy aimed at mitigating the levels of bullying behaviour presenting in the centre.
- The director of service must review at the SERG meetings how life space interviews are conducted and look at ways to encourage young people to engage in the process.

- The director of service, as the registered provider, must review the auditing system to ensure that practices aimed at monitoring the residential centre's approach to managing behaviour that challenges are in place.
- The centre manager must review all Individual Crisis Support Plans to ensure that clear and specific interventions to manage risk behaviours are stated.
- The centre manager must ensure that all Individual Absent Management Plans are up to date.
- The centre manager must review the purpose and function of behaviour support plans and ensure that all individual plans in place for young people are routinely discussed at staff team meetings.
- The director of service, as the registered provider, must review the auditing system to ensure that practices aimed at monitoring the residential centre's approach to managing behaviour that challenges are in place.
- The director of service must immediately develop a policy and procedure on restrictive practices that complies with criteria 3.2.6, 3.2.7 and 3.2.8 of the HIQA Standards, 2018.
- The director of service must conduct a full review of the complaints process in place in the centre and ensure all findings in this report are included in the review.
- The director of service must develop a feedback template to gather opinions from parents and social workers on the provision of care being provided to young people and that it informs service improvement.
- The director of service must review the processes for recording and reviewing incidents that staff are part of the review process and ensure that learning is effectively communicated back to the staff team.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director of service, named as the relevant person in the child safeguarding statement must identify those members of staff who have mandated responsibilities, that all staff read and sign the statement and ensure that the statement is publicly displayed in the centre.	Completed. The director of service has identified staff who have mandated responsibility, they have signed the safeguarding statement which is now publicly displayed within the centre.	The director of service will ensure the statement is publicly displayed and that is implemented in full.
	The director of service must update the anti-bullying policy to ensure that there are appropriate procedures in place that ensure bullying behaviour is managed to prevent harm to young people.	Completed. The anti-bullying policy has been updated to include procedures for managing bullying behaviour.	The director of service has scheduled a review of the revised anti bullying policy for October 2021.
	The director of service must review and update the child protection and welfarepolicy document immediately to address the deficits outlined in this report, provide staff with refresher child protection training and satisfy themselves that all staff fully understand the practice of	Completed. All staff have been reminded of their role as mandated people and this reminder will continue as and when needed. All new staff commencing their employment will be required as part of their induction to read understand and sign this policy. All existing staff have read	Through governance arrangements and oversight the director of service will ensure that all areas relating to child protection and welfare will be monitored including training. A review of the child protection and welfare policy is scheduled for October 2021.

	safeguarding and adherence to Children First guidelines.	and signed the new updated version of the policy. Training is scheduled to take place on the 4th of August 2021.	
	The director of service must strengthen centre and senior management governance systems to ensure that they are robust in identifying and managing child protection and welfare concerns and monitoring safeguarding practices.	Completed. All child protection concerns (CPC's) will be discussed at monthly managers meetings. For concerns that do not meet the threshold for reporting the reasons for same will be recorded on the CPC Form. Governance systems have been strengthened to capture concerns and assess safeguarding practices.	Through monitoring and oversight the director of service will oversee the implementation of the revised auditing framework to ensure that it identifies child protection concerns and how they were responded to.
	The director of service must review the risk management framework to ensure that effective processes are in place that identify, assess and manage risks and that it includes preadmission risk assessment processes and centre management, and staff should work collaboratively to promote the safety and wellbeing of children.	Completed. Potential new admissions to the centre will be risk assessed using the framework identified by the organisation.	The centre's risk management framework will be reviewed as part of the risk assessment and management policy review that is scheduled to take place in October 2021 to ensure it's effective and working for the centre.
	Senior management must ensure that a more robust key working system is developed that ensures comprehensive programmes and plans that support young people in developing skills for	Completed. A key working plan has been introduced that identifies what work will be completed within the first three months and six months of a young person's admission. All placement plans will be	The director of service will monitor the revised keyworking system as part of their oversight of practices within the centre. All key work undertaken with the young person will form part of the auditing framework.

	self-care, self-awareness, understanding and protection are developed, that it looks at improving engagement between keyworkers and young people and includes clinical support.	reviewed at the clinical meeting moving forward to ensure that there are no gaps within the keyworking system and for further oversight by other professionals.	
	The centre manager must review the protected disclosures policy with the staff team immediately.	Completed. This will be included in the child protection training scheduled for the 4th of August 2021.	The director of service will ensure that a system is in place whereby the protected disclosures policy is regularly reviewed with staff in the centre.
	The director of service must ensure that processes aimed at managing challenging behaviour are reviewed and strengthened immediately and that management and staff are clear of these following the review process.	A physical intervention register has now been introduced. A behavioural analyst will now form part of the SERG meetings. They will assist staff in identifying behaviours and completing behavioural management support plans to bring about change for the young people.	All the systems identified will be included in the auditing framework
	The director of service must develop and oversee the implementation of an anti-bullying strategy aimed at mitigating the levels of bullying behaviour presenting in the centre.	Completed. The anti-bullying policy has been revised and strategies for dealing with bullying behaviour have been identified. This work will take place in conjunction with all resident young people's social workers.	The strategy will be reviewed as part of the anti-bullying policy review scheduled for October 2021.

	The director of service must review at the SERG meetings how life space interviews are conducted and look at ways to encourage young people to engage in the process.	Completed. The clinician will now support the staff team in looking at strategies on how to engage the young people better.	The completion of LSI's will now be covered in the centre's auditing processes.
	The director of service, as the registered provider, must review the auditing system to ensure that practices aimed at monitoring the residential centre's approach to managing behaviour that challenges are in place.	An external auditor is developing a framework that will strengthen the auditing process and will include the centre's approach for managing challenging behaviour.	The director of service will oversee all audits relating to centre practices including the centre's approach for managing challenging behaviour.
	The centre manager must review all Individual Crisis Support Plans to ensure that clear and specific interventions to manage risk behaviours are stated.	Completed. A copy of the ICSP's have been forwarded to the young person's social worker for comment/review.	As part of oversight the director of service will ensure that all individual plans for young people are in place and will include all the required information.
	The centre manager must ensure that all Individual Absent ManagementPlans are up to date.	Completed. All are now up to date.	As above.
	The centre manager must review the purpose and function of behaviour support plans and ensure that all individual plans in place for young	Completed. The behavioural analyst will assist staff in identifying behaviours and completing behavioural management support plans for staff to work in line with	This will form part of the centre's auditing framework.

	people are routinely discussed at staff team meetings. The director of service must develop without delay a policy and procedure on restrictive practices that complies with criteria 3.2.6, 3.2.7 and 3.2.8 of the HIQA Standards, 2018. The director of service must conduct a full review of the complaints system and ensure all findings in this report are included in the review.	and to bring about change for the young people. Completed. A copy has been provided to ACIMS. Completed. A copy has been submitted to ACIMS.	 As part of their oversight the director of service will ensure that the restrictive practice policy is implemented and monitored. The policy will be reviewed in July 2022 As part of their oversight the director of service will ensure the centre's management to complaints aligns to policy.
	The director of service must develop a feedback template to gather opinions from parents and social workers on the provision of care being provided to young people and that it informs service improvement. The director of service must review the processes for recording and reviewing incidents, that staff are part of the review process and ensure that learning is effectively communicated back to the staff team.	Completed. This feedback will now form part of the centre's monthly auditing process. Completed. All staff members now attend the SERG meeting.	The director of service will, in their role, use information returned via feedback forms to inform service improvement. All staff members will now attend the SERG meeting chaired by the behavioural analyst and attended by the consulting clinical psychologist and director of services.