An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 166

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Harmony Residential Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**16th, 17th & 21st November 2022**
Registration Status:	**Registered from the 12th of April 2020 to the 12th of April 2023**
Inspection Team:	**Eileen Woods** **Cora Kelly**
Date Report Issued:	**16th March 2023**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation 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 as a semi-independent centre on the 12th of April 2020, it had previously registered as a special arrangement in 2019. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from the 12th of April 2020 to the 12th of April 2023.

The centre was registered to provide care and accommodation, in self-contained apartments, for up to four young people aged between 16 and 17 years of age in order to prepare them for leaving care. Their model of care was described as informed by a therapeutic based approach of cognitive behaviour therapy that focused on the total behaviour of the young person. There were three 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
1: Child-centred Care and Support	1.6
2:Effective Care and Support	2.6
3: Safe Care and Support	3.2, 3.3
4: Health, Wellbeing and Development	4.2

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 19th of December 2022 and to the relevant social work departments on the 19th of December 2022. 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 18th of January 2023. This was deemed to be satisfactory and the inspection service received some evidence of the issues addressed to date with additional implementation dates listed as upcoming. A further inspection will take place to review the progress of the implementation of the corrective and preventative action plan. This will include a review of the premises. The inspectorate needs to be assured the centre is in compliance with the standards. Failure to provide evidence of improvement and implementation of the CAPA as submitted may lead to regulatory action and conditions being attached to the registration of the centre.

The findings of this report and assessment of the submitted CAPA, if implemented in full, deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 166 without attached conditions from the 12th of April 2020 to 12th of April 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

This preparation for leaving care centre, for sixteen to seventeen year olds on admission, of individual flats co-located with a staff apartment had a number of methods in place to consult with the young people in their care. There was an open-door policy and common area in a staff apartment where meals were provided daily and staff available to meet the young people. Staff provided both general daily company and meals alongside focused interventions inclusive of key working, activities and support with appointments for all the residents. There was a social care manager and a deputy social care manager available on the same site, and inspectors found that the team were hard working and aiming to provide good care. There were policies in place on children's rights, consultation and on working in partnership with children, families and professionals. These policies do not currently contain reference to the older age group of this centre and inspectors recommend that the team review those policies and identify if there should be specific aspects for the purpose and function of the centre.

The views and preferences of the young people were recorded on the plans maintained by the staff team, for example the young people had been consulted about what their aims were regarding preparation for leaving care through a preadmission placement plan which formed a needs assessment. They were also consulted on what help and support they would like, or thought might work for them when in crisis or struggling with harmful behaviours.

The policy on consultation contained a section on facilitating young people's meetings, the procedures within this contained the aim to have young people chair and record the meetings but these had not taken place as yet. There were young people's meeting records maintained and inspectors found that it was difficult to ascertain who was physically present or who was consulted with separately after the meeting. The team should note if meetings were group or individual. Whilst the meeting followed a structured format, they were not utilised for example to positively ground young people in their responsibilities to their apartment, to their co-

residents, to staff. Where disputes arose the staff offered complaints forms to young people and it was not the practice to utilise a restorative practice approach which would be reflective of local resolution at the earliest point. The young people's meetings did not reflect the purpose and function of the project to the extent that it could. Inspectors also noted that where items were raised, such as specific repairs required, that the management must ensure in their responses to note actions for same.

The organisation had put procedures in place to gather feedback from young people who had left the project. A young person had raised an idea to benefit the project and this feedback was known by the staff during this inspection, inspectors recommend that this valuable feedback be included in induction and policy in due course. The young person had made suggestions around the use of language and moving away from jargon where possible.

There was a complaints policy in place and inspectors found that the policy was in the main implemented in accordance with its identified procedures. The complaints were tracked though a register and were formally notified to the social work departments involved. The inspectors reviewed complaints from the period of the previous inspection activity with the centre, completed in March 2022 and found that one complaint was on record and this had been escalated to a child protection concern by the Senior Quality Assurance Manager and deputy DLO. The social worker for the young person reviewed this matter and determined that there was no child protection issue nor a valid complaint to answer. The young person also withdrew the complaint. CCTV confirmed that staff practice was fair and safe. This matter was confirmed as closed by the social worker involved.

The records of complaints followed a system of A – D procedures, with A representing locally resolved matters managed and responded to at the first point of contact with staff. These 'Grade A' complaints records were written and not all were signed, the young person's views were not always recorded on the relevant section and the feedback not contained within them either. The staff must complete the forms fully and must also reflect on how negative comments and emerging disagreements between peers can be addressed locally as well as offering formal complaints. This could be used as a way to assist young people to manage and negotiate shared living arrangements in preparation for aftercare. The team need to better record young people's feedback post complaints conclusion.

The three young people responded in questionnaires provided by inspectors, two young people also met with inspectors and told us they had been informed about how to make a complaint and inspectors found this work evidenced in key working records and in the admissions procedures both verbal and written. One young

person said they made a complaint and were happy with the outcome, inspectors were informed that the resolution they described was not the actual ultimate outcome. Inspectors were made aware that this would be clarified with the young person. Another young person spoke about disputes related to fair access for all the residents to internet access and the director of service told inspectors that actions had been taken to address this and improve access for all.

There had been complaints auditing completed by internal and external management in 2022. Inspectors did not find though that there was a good awareness of trends and themes in complaints and what this may mean for future centre development. For example, where conflict was building within the group of peer's minor issues were not identified as an early indicator of later complaints. At the time of this inspection visit a young person told inspectors that they felt unsafe living at the centre due to conflict with a peer, a pattern that inspectors could observe through the young people's meetings as co-living irritations being expressed at an earlier stage. Inspectors raised concerns related to young people's views and mood with the centre management, the senior management and the social workers and all parties were aware and alert to the young people's immediate safety needs.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The management and staff must review the format and recording of the young people's meeting to suit the age range, indicate who was present, who was consulted and to provide consistent responses to queries raised.
- The staff and management must ensure that disputes and group discord arising within groups of young people are identified for action and attention at the earliest point.

- The staff and management must ensure that the forms utilised for recording all types of complaints are fully completed through to recording feedback and views post completion.
- The senior management and quality assurance team must ensure that they identify and address patterns emerging from consultation, complaints and feedback for strategic response measures and future planning.

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

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

There was a preparation for leaving care programme evident in the physical layout of the centre being individual apartments. The preadmission risk assessment was extensive and was predominantly an assessment related to risks and presenting behaviours and not as an initial assessment of readiness or a personal wish for a more independent style setting. In fact, the social workers in the main noted that the young people had no other alternative placement types offered to them at that time, this centre was a placement open to working with the issues the young people presented with. Inspectors recommend that the organisation increase the focus on readiness or wish for this type of programme at the preadmissions stage and improve the focus on those specific outcomes in their discharge reviews to increase the identification of the centre in line with its core purpose.

There was a preadmission placement plan and life skills assessment which was completed to identify needs and a budgeting programme was in place. The placement plans thereafter evidenced actions related to education, training, and employment options. Inspectors noted a need to focus more consistently on benchmarking the Tusla care plan goals, the Tusla aftercare plan goals and the centre's own preadmission placement plan goals with how they are reflected in the placement plans and tracked thereafter to increase the representation of the life skills aspect of the work.

Inspectors heard from staff and the young people themselves the specific life skills completed, for example mock interviews and CV's created and updated, courses done for employment purposes and jobs sourced with the young people. It would be important for the centre to create better tracking and recording systems for life skills work in a manner that may allow, for example, for information to be taken with the

young person when they leave. A more robust approach to the life skills programme may help support the focus away from the harmful behaviours and incidents, in particular significant property damage and child protection issues, that had been taking place in the centre throughout different cohorts of young people in the past year.

The young people had care plans on file and one young person nearing 18 years had an aftercare needs assessment on file. The aftercare plan had been completed and the aftercare manager from this young person's area was in charge of the case with the social worker to complete planning for accommodation and support post eighteen. The social worker and the aftercare manager named the particular difficulties faced by young people from regions which have limited aftercare beds and who also had lived in care outside their birth region for most of their life.

The other young people were aged sixteen and both social work departments identified internal Tusla waiting lists that might impact their assignment of an aftercare worker that they required at the earliest possible point in line with their complex needs. Both social workers involved were pursuing allocation of an aftercare worker as a priority. The three social workers named that regular communication and meetings occurred in relation to the young people's care. The social workers differed in their views in the effectiveness and focus of that care in being therapeutic and proactive enough. The property was described as both good quality and as bare of furniture and lacking any homeliness. Inspectors found during our visit that a young person's apartment was lacking furniture, and in the process of another round of repairs from extensive property damage. It was also described as bare in a different apartment by another professional. The centre management and senior management named that extensive damage to property had taken place and that repairs were completed without delay. The maintenance records identified that whilst repairs to walls and fittings took place it is recommended that an audit be completed on the overall furnishings and fittings in each apartment.

The key working records and the placement plan often didn't reflect the independent living skills to the extent that it could, and staff must amplify on the records where they have worked with the young people to identify and achieve their goals. Inspectors found that the core documents for recording, such as the key work records could be modified to be reflective of the specific purpose and function. Inspectors found that tracking of reasonable timeframes and achievable and achieved goals must also be improved.

There was a high level of daily support with a managed expectation of independent living skills in their apartment. The staff identified that many of the young people referred to the service had a low level of life skills upon admission and required a

high level of support, which they duly provided. For example, a young person may have had over 20 short term/temporary, or emergency moves before admission to the centre whose task over a short period of time would be to try to support them towards aftercare. The level of support or expectation of self-care would be young person led once a young person neared the age of eighteen where that capacity existed. The whole team had good practical local links and local engagement and the good quality knowledge on the team was put into action for the young peoples benefit.

The centre staff were working with the social workers to ensure that core documents were sourced for the young people such as birth certificates and passports to assist in opening back accounts and applying for jobs and services. Inspectors found that staff should familiarise themselves more with the Tusla national aftercare policy and procedures; documents are available on the Tusla website. The regional manager informed inspectors that they are soon to join Tusla regional aftercare network meetings also.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 2.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management and staff must focus more consistently on benchmarking the care plan goals, the aftercare plan goals and the centres life skills and young person's goals with how they are reflected in the placement plans and tracked thereafter to increase the life skills aspect of the work.
- The registered proprietor and centre management team must integrate a readiness or wish for this type of programme by a young person at the preadmissions stage and improve the focus on those specific outcomes in their discharge reviews to increase the identification of the centre in line with its core purpose.

Regulation 5: Care practices and operational policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

The centre had a policy on behaviour management and a policy on challenging behaviours, these had been reviewed in 2022 as part of wider policy review. As stated the purpose of the centre was preparation for leaving care for all young people including those with emotional and behavioural challenges. The staff implemented a resilience and strengths-based model and were positive in their approach to the young people. The young people themselves noted that staff offered them support in the areas of their emotions and behaviours that were causing them most concern and most difficulty. Two of the young people stated that they couldn't think of anything else that would help but were thankful to the staff for being available to them and trying to assist them. Some social workers and allied professionals stated that the centre had maintained young people despite many challenges and found them to be professional and committed. Another social worker noted that the therapeutic care aspect could be more prominent and integrated than it currently was.
Inspectors received an internal Tusla risk escalation regarding incidents that had occurred in the centre in October of 2022 and inspectors reviewed these events alongside general trends in incidents as an additional part of this yearly inspection visit. Inspectors found that the volume of issues arising led to warnings on all three current placements and some previous placements in 2022. The numbers and types of incidents included child protection reports, contact with gardai inclusive of charges and repeated destruction of the property which indicated a need for a full review of the centre to ensure that they can meet the purpose and function more effectively in a safe and well-maintained environment. Inspectors acknowledge that there were mechanisms in place to monitor, improve and evaluate quality, safety and continued care provided to children but they were not always effective or adequately responsive to meeting young people's safety needs as was intended.

There were practice guideline folders in place for all three young people, these had been updated regularly, typed, and dated but were frequently unsigned. There was reference to the use of a CBT informed model of care throughout and some descriptive evidence of its use. In line with this model there was reference to supporting young people to better emotional regulation and work on feelings and thoughts, but without the detail of how this might be or was realised in practice. The

inspectors could clearly see the level and standard of planning in response to the behaviour management issues and acknowledge the amount of work and commitment shown in these. Inspectors found that the plans in place related to behaviour management must be reviewed by the company regarding their volume and length to investigate if they were effective and could be updated in a timely manner.

The senior management stated that they had not offered placements to a number of young people based on the pre admission risk assessment approach and worked hard to identify who could benefit most from the service. Inspectors and the centre team noted that in the instance of some recent admissions their incident profiles in the months prior to their referrals may have lacked detail following a period of time spent moving around temporary special arrangements provided by Tusla.

The young people had behaviour support plans (BSPs). These were completed by staff, reviewed by management, and could be inclusive of clinical team input. Inspectors found that these had not been accurately updated at the time of the inspection to include key issues including specific conflict with a co-peer, assault of a co-peer, warnings issued, further detail on declining mental health. Overall inspectors found the BSPs would benefit from a sharper focus on key areas for example, how to stop young people breaking day to day rules at the centre or on how a young person on a final warning might earn back their place in the programme or serious mental health concerns.

The staff team met monthly so the main vehicle for the sharing of information on updates and responses to incidents was through handovers in the interim. Inspectors found that this was not sufficient for planning of the care of young people and meetings should be three weekly or preferably fortnightly to plan. Inspectors found that the system of assignment of supervision duties, inclusive of debriefing, to social care leaders may be too diversified an approach given the nature of the needs of the placements at the centre. These factors coupled with infrequent significant incident review groups being held presented as issues that inspectors found must be reviewed. During this inspection visit on the 16th of November serious incidents from the preceding weeks had not been subject to a SERG review to inform staff practice despite damage to the property and the staff car resulting in the need to vacate the property temporarily.

There were absence management plans on file for the young people. There were some slight differences in these and should be reviewed to ensure all three carry a true reflection of the risk factors that could rapidly escalate an absence to a missing child in care such as risk of self-harm.

The young peoples practice guideline folders also held risk assessments and as with the BSPs there was good quality content in templates, review of same and practices identified within them. Inspectors found though that there were many on file, they were long, broad at times with anomalies in updating in a timely manner, for example a risk assessment on weapons had not been updated to include the use of and the finding of an item used as a weapon two weeks before and that this was used in an assault on a co-peer.

Two staff required training in the centres recognised method of management of challenging behaviour and some staff required refreshers. Some of the staff were unclear as to the frequency that refreshers should take place and were unclear about what physical interventions could be used and how they should be recorded depending on the level used. The BSPs did not clearly state regarding what contraindicators there were to restraint, for example the size of young people, structure of the centre, intoxication or if untrained persons on duty. At interview staff were not clear about if restraint or physical intervention could be used and if so what holds and this information was not represented in the plans either. It is several pages into an eight-page BSP and not in the restraint/holds section that, in one example, reference to 'no physical restraint unless absolutely necessary' was found. The verbal intervention techniques were well represented on the BSPs and presented as possible to implement.

There was a register of restrictive practices in place and a procedure implemented. Inspectors found that restraints were not fully accounted for as a restrictive practice. Inspectors also found that the centre must consider how and when young people are made aware of a restrictive practice being in place and being debriefed as per the standard should that be required by the nature of the particular restriction.

Inspectors reviewed discharge reports and found that these accepted a level of challenging behaviours and relied on scores which were not always supported as being grounded evidence for progress.

The organisation operated a system of on call with graded levels of seniority available and criteria for each. The serious incidents escalated in late October noted clear issues related to the role of on call. The senior management team had acknowledged these concerns and had initiated an audit with the persons involved in on call.

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

The centre, as stated, had a system of monthly team meetings and supervision in place for all staff. There were daily handovers in place also as forums to raise concerns regarding placements and discuss areas of improvements in ongoing interventions. There were meetings with young people themselves to have open discussions post incident and to deliver written warnings when the centre determined, due to the severity of the incidents, that same was required. There were professionals' meetings involving all the social workers following significant group incidents for open discussion as well as individual regular consultation. There were updated risk assessments and safety plans generated with respites and offsite living utilised on occasion.

The registered provider had a policy and system for the reporting of significant events. There was a tracking sheet attached to all SENs on file that noted who they were sent to and when. Inspectors found though that the SEN register was incorrect with index numbers not accurately assigned and at times descriptors not fitting the actual event and date. All the SENs on file had comments from the centre management and from the regional manager, where required due to the severity of the incident's comments from the director of service were present too.

Inspectors found the need to link SEN content to behaviour and risk management plans in a more detailed way and be clear in the content about situations, to allow for thorough follow up on developing staff practice and noting gaps in knowledge that must be addressed. Where significant event review group, SERGS, were referenced as going to be done or as required there was not always a corresponding SERG completed. The team and the organisation need to complete SERGs and debriefs in a timely manner to be able to implement changes and/or to affirm effective and positive practices. Inspectors recommend that from these reviews that response plans are updated in a leaner way so staff can access and implement them without delay.

Inspectors also found that trends needed to be identified and amplified for action from SENS more clearly, for example a number of young people were accumulating new criminal charges for property damage whilst living at the centre and these did not seem to be tracked. Alongside this it was difficult also for inspectors to identify consistent thresholds for when placement warnings were issued. There must be better analysis of SENs with linking the learning more rapidly to enhance practice and reduce the serious nature of the recurring incidents at the centre.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 3.2** **Standard 3.3**

Actions required

- The registered proprietor must complete a full review of the centre to identify how the centre can meet it purpose and function effectively and in a safe and well-maintained environment.
- The senior management team and centre management must review the numbers and types of behaviour management related plans for effectiveness, ease of use, responsiveness, accuracy in relation to recent events.
- The centre management must clarify on the relevant sections of the plans what the criteria and contraindicators are to the use of restraint and physical interventions.
- The centre management must ensure that all staff who require training or refreshers in the method of management of challenging behaviours have same booked and completed as a priority.
- The senior management team and the centre management must ensure that there is better analysis of the content of the significant event reports to ensure accuracy and support more rapid learning towards reducing the serious nature of the recurring incidents at the centre.
- The centre management must ensure that they accurately maintain the SEN register and correct errors noted to date.
- The centre management and the senior management team must complete SERG in response to critical incidents and in response to ongoing issues in a timely manner.
- The senior management team and centre management must review the scheduling of team meetings in line with the care needs and operational practices.

- The management team must consider how and when young people are made aware of a restrictive practice, as per the standard, should that be required by the nature of the particular restriction.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The young people's files contained health sections that detailed the teams work with the young people to access the health services they required, move GP as needed and to attend essential appointments. There was evidence that the young people were supported to gain an understanding of what they needed to organise for themselves in the future. There was evidence that they were encouraged to take ownership of their health needs through both informal and formal opportunities taken by staff for life skills work. The three young people had moved from their original GP provision and had to be established with a new GP service. Shortages in local GP lists resulted in appropriate actions being taken by the team to secure good primary care for a young person. The young people were supported with action to get a medical card or to update their medical card. There was evidence of use of emergency or out of hours GP services also where needed. Dental and optical appointments were made and followed up in efforts to support the young people to attend. Childhood immunisations records were either on file or actions in place to try to secure them with the young people's involvement.

The team had established links with a local substance misuse service and worked with them and relevant young people to address this area. The mental health needs of this and previous groups of young people were complex and had often been untreated for periods of time prior to admission regarding their underlying trauma and disabilities, such as oppositional defiance disorder, ODD. The team were linked to additional suicide awareness and intervention charities like SOSAD and youth mental health service Jigsaw. The team could request clinical team input and this advice was shared in the relevant young people's plans and there were tools provided to assist in difficult conversations for example around grief and loss. An anger management specialist from the clinical team was due to commence direct one to one work with a young person. Another young person's referral had been accepted by the local CAMHS and they had commenced appointments.

There were risk assessments on low mood which included staff being trained in first aid as central to responses outlined. Inspectors found that these risk assessments whilst good should be more specific and up to date regarding statements made in relation to intention to self-harm or very low mood. Inspectors recommend that the staff record more specifically what increased checks look like regarding intervals or in recording interventions to help regulate mood be broken down into specifics. The staff evidenced getting up at night and supporting young people in distress, this included on occasion all night checks. Some records were clear on what was done to support in these situations other records were not as explicit and the team must look to share learning by keeping accurate records in such demanding and difficult situations in order to build knowledge base. There was evidence of support being given with self-harming and social and emotional education on harmful habits in relationships that triggered self-harming episodes. Inspectors found the team were caring and concerned for the young people's mood.

Inspectors found that the staff must revise their knowledge of ligature procedures and location of the relevant cutters and clearly record their protocols for checking apartments where concerns exist. There were differing answers given on the potential seriousness or not of specific events linked to same and about whether the team had covered the use of the cutters in their first aid training. It is important that this safety measure is practiced and that the whole team have awareness of its role. The team had completed basic first aid training with a plan in place to have numbers of senior staff, in the first instance, complete the full First Aid Responder (FAR) training starting in 2023.

The staff team had completed recent training in medications management and the system related to this was almost fully rolled out with the final aspect of its dedicated monthly audit tool to be implemented and the policy was being updated in line with the new training received.

Compliance with regulations	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management and staff must revise their knowledge of ligature procedures and location of the ligature cutters and clearly record their protocols for checking apartments where concerns exist.
- The centre management, staff must endeavour to update mental health and self-harm related risk management and safety plans on an ongoing basis related to specific actions and statements of young people.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The management and staff must review the format and recording of the young people's meeting to suit the age range, indicate who was present, who was consulted and to provide consistent responses to queries raised.	The Senior Quality Assurance Manager met with the Centre Team on 13.01.2023 to discuss this action. A member of the centre staff team has volunteered to complete a review of the format and recording of the young person's meetings. This will be completed by 20.01.2023 and reviewed by senior management for immediate implementation following same.	Weekly oversight will take place from the Centre Management team of these meetings in line with this action. Any issues identified will be responded to weekly. This CAPA action will also be reviewed monthly with the Centre Management Team and the Regional Manager to ensure the new processes of young person's meetings and recordings are working effectively. Any deficits will be responded to via review and action planning. When no longer required to be reviewed monthly, the oversight will extend to the monthly auditing system at internal management level.
	The staff and management must ensure that disputes and group discord arising at young people's meetings are identified for action and attention at the	A member of the internal management team has volunteered to develop a continuous professional development (CPD) session for the team around	The new CPD session will be included in the new employee development programme that came into effect in January 2023. The CPD will ensure all

	earliest point.	responding to disputes and group discord at the earliest point. The CPD session will be scenario based to promote individual and team learning. The CPD will be completed by 20.01.2023 to be reviewed by senior management for implementation. The CPD session will be completed with the full team at the subsequent team meeting.	employees and future employees are informed about the importance of early intervention and proactive responses at the earliest point of discord. Further supporting this action is the update to the monthly centre report shared with the senior management team for governance and oversight which now covers the topic of group living and a section to reflect on any issues that may be arising and planned responses. Oversight and governance including further responses if required will take place from senior management. This updated form has been shared with this inspection response.
	The staff and management must ensure that the forms utilised for recording all types of complaints are fully completed through to recording feedback and views post completion.	With immediate effect, the Centre Manager and Deputy Manager are responsible for ensuring the complaint form for informal and formal complaints are fully completed. In addition, the grade A informal complaint form has also been updated as of 09.01.2023 to include a section on feedback from young people as this was previously not included on this	This CAPA action will be reviewed monthly with the Centre Management Team and the Regional Manager that all complaint forms from Grade A to D are completed in full when a review of complaints and escalations take place. Any deficits will be responded to via review and action planning. In addition, there has been a change to the policy and procedures as of

		form. The updated form has been shared with this inspection response and is in implementation across the organisation as of 09.01.2023.	16.01.2023 relating to complaints, where all complaints, regardless of grade must be shared with the complaints officer fully completed. The policy update and associated CPD has been shared with this inspection response.
	The senior management and quality assurance team must ensure that they identify and address patterns emerging from consultation, complaints and feedback for strategic response measures and future planning.	Corrective actions and timeframes relating to this action are: 1. Update to policy and procedures on complaints to include that all grades of complaints are to be shared with the complaints officer. This is effective as of 16.01.2023. 2. Update to the complaints register prompting the submission of all complaint forms to be shared with the complaints officer. This is effective as of 16.01.2023. 3. Update to the Monthly Centre Report to include a section on group living to allow for analysis of any issues arising outside of complaints. This will be effective as of 01.02.2023.	The Senior Quality Assurance Manager has developed a tracker and will gather all data from the monthly centre report and also all grades of complaints and track any patterns emerging. An evaluation will take place to ensure measures have been taken to address any patterns emerging. If there are deficits, further action and planning will take place to ensure strategic response measures and future planning.

		All of the above have been shared with this inspection response.	
2	The centre management and staff must focus more consistently on benchmarking the care plan goals, the aftercare plan goals and the centres life skills and young person's goals with how they are reflected in the placement plans and tracked thereafter to increase the life skills aspect of the work.	The internal management team have been assigned to review the placement plan template in the Centre as of 13.01.2023. The internal management team will work together and include the Centre team in a revision of the current template with a focus of improving the benchmarking of all goals and skills as named and to improve the outcome and tracking of the life skills aspect of the work completed in this Centre. The placement plan will be updated by 28.02.2023 and implemented on review from the senior management team.	The case manager will be responsible for overseeing this action monthly via placement plan review. In addition, this CAPA action will be reviewed monthly with the Centre Management Team and the Regional Manager to ensure the new processes are working effectively. Any deficits will be responded to via review and action planning. When no longer required to be reviewed monthly, the oversight will extend to the monthly auditing system at internal management level.
	The registered proprietor and centre management team must integrate a readiness or wish for this type of programme by a young person at the pre admissions stage and improve the focus on those specific outcomes in their discharge reviews to increase the identification of the centre in line with	The template for the pre-admission impact risk assessment for this Centre has been updated as of 16.01.2023 to include a section to identify the readiness for this type of programme based on the young person's strengths, skills and abilities. This will be implemented with immediate effect for all future admissions. In addition, the	Young people's placements are reviewed monthly at the Regional Manager Centre Meetings with the Management Team. Any issues arising will have a planned response in line with the Organisations escalation policy. The new measure relating to the pre-admission impact risk assessment will be reviewed by management before a

	its core purpose.	registered proprietors will discuss this CAPA action with the NPPT on Monday the 23rd of January 2023 at the contract review meeting and put forward two suggestions the organisation has relating to having young person and social work feedback relating to the wish and readiness for this type of programme at the referral stage. An update to the inspectors will be completed following this meeting. The discharge review template has also been updated to promote more focus on outcomes in line with the Centre's core purpose and function. This updated document has been shared with this inspection response.	placement is offered to a young person. We hope to have an additional update post contract review meeting relating to the two suggestions we have to promote this CAPA action further to ensure an issue like this does not arise again.
3	The registered proprietor must complete a full review of the centre to identify how the centre can meet it purpose and function effectively and in a safe and well-maintained environment.	The registered proprietor and senior management team will hold a review meeting of this Centre by January 31st, 2023, to identify additional measures that are required to ensure the centre can meet the purpose and function effectively and in a safe and well-maintained environment. A subsequent meeting will also occur with the Centre Management team also relating	This CAPA action will remain live and discussed monthly at the Regional Manager Centre Meetings to ensure that any issues arising are responded to accordingly and in a timely manner. This preventative measure will be further supported by the other measures we have identified such as the update to the pre-admission impact risk assessment and the

		to this. Any actions identified will be responded to. The director of social care is responsible for ensuring same.	other measures we have identified to discuss with the NPPT.
	The senior management team and centre management must review the numbers and types of behaviour management related plans for effectiveness, ease of use, responsiveness, accuracy in relation to recent events.	This action and the below action were discussed with the Centre staff team on 13.01.2023. Two members of the team and a member of the internal management team are going to work together to complete a full review of the behaviour management plans. This will be completed by 10.02.2023 and shared with the Organisation MAPA trainers for review and implementation.	The MAPA trainers will review the revised behaviour management plans and develop a CPD session on these to complete with the team. The centre management team will be responsible for conducting internal audits on the behaviour support plans to ensure these are effective, up to date, easy to use and responsive to the needs of the young people.
	The centre management must clarify on the relevant sections of the plans what the criteria and contraindicators are to the use of restraint and physical interventions.	This action will be completed during the process of completing the above action. Timeframe for completion – 10.02.2023 whereby a review from the MAPA trainers will take place prior to implementation.	The MAPA trainers will review the revised behaviour management plans and develop a CPD session on these to complete with the team. The centre management team will be responsible for conducting internal audits on the behaviour support plans to ensure these are effective, up to date, easy to use and responsive to the needs of the young people.

	The centre management must ensure that all staff who require training or refreshers in the method of management of challenging behaviours have same booked and completed as a priority.	The three staff members who required the full MAPA training received their training on 14th and 15th of December 2023. Certificates shared with this inspection response. Refresher training is scheduled for February 7th, 2023, for the employees who require refreshers in MAPA.	An annual training plan has been developed whereby training for MAPA is scheduled throughout the year at different intervals – whereby trainers and venues have been booked in advance. This is also in place for other mandatory trainings. The annual training plan has been shared with this inspection response.
	The senior management team and the centre management must ensure that there is better analysis of the content of the significant event reports to ensure accuracy and support more rapid learning towards reducing the serious nature of the recurring incidents at the centre.	A review of the oversight and governance section on the significant event notifications has been completed by the senior management team. The review to the documentation will allow oversight and governance of incidents to be more specific and effective and to place more emphasis on analysing the content of all incidents in a solution focused way. This new template will be implemented by January 31st, 2023. A copy of this updated incident report form has been shared with inspectors.	The senior management team will continue to complete oversight and governance on all incidents in the Centre and provide further guidance on interventions where necessary to support more rapid learning towards reducing incidents.
	The centre management must ensure that they accurately maintain the SEN	The Centre Manager with immediate effect will be responsible for maintaining the	Internal audits will continue to take place to ensure this action does not occur again.

	register and correct errors noted to date.	SEN register. The deputy manager will be delegated this task in the Centre Managers absence. The review of the current register is underway and will be completed by the 20.01.2023.	Any deficits found in accurately maintaining the SEN register will be responded to immediately.
	The centre management and the senior management team must complete SERG in response to critical incidents and in response to ongoing issues in a timely manner.	This CAPA action will be discussed at the next management meeting (February 2023) whereby a review of the policy and procedures on SERG reviews will take place with the policy review group and the Centre management team to ensure that a timeframe for the completion of these is implemented on the policy to meet this action.	This CAPA action will be reviewed monthly at Regional Manager Centre Meetings and a review of SERG reviews will form part of these discussions to ensure that critical incidents have a SERG completed in a timely manner. When this action no longer requires a monthly review, the oversight and governance will extend to quality assurance auditing.
	The senior management team and centre management must review the scheduling of team meetings in line with the care needs and operational practices.	Effective 13.01.2023, team meetings will be held every three weeks. The deputy manager is responsible for scheduling these meetings as per centre rostering.	The Centre manager will be responsible for ensuring that team meetings occur every three weeks. This CAPA action will be reviewed monthly by the Regional Manager and Centre Management team until deemed no longer required. This oversight will then extend to the quality assurance auditing.

	The management team must consider how and when young people are made aware of a restrictive practice, as per the standard, should that be required by the nature of the particular restriction.	The quality assurance manager will conduct a review of all restrictive practices in this centre and identify any required actions to be completed. In addition, the restrictive assessment form has been updated to reflect this feedback and implemented effective of 16.01.2023.	As stated, the restrictive practice assessment form has been updated to reflect the deficits found during inspection with the aim of preventing this issue from arising again. The Centre Management team conduct monthly reviews of restrictive practices at the team meeting and oversight will take place at this forum monthly and it will also be extended to quality assurance review under the external audits.
4	The centre management and staff must revise their knowledge of ligature procedures and location of the ligature cutters and clearly record their protocols for checking apartments where concerns exist.	Ligature training took place on December 16th, 2023, by an external trainer. A member of the internal management team is in the process of developing an Organisational Policy and procedures on same in partnership with the external trainer. This policy will be completed by end of January 2023 and implemented in this Centre following review from the policy review group. The policy will be reviewed in full with the Centre team once approved for implementation to ensure all information is clearly communicated to	The centre management team and senior management team who review the incidents in the Centre and the weekly reports will ensure that the protocols for checking apartments where concerns exist are clearly recorded. Any deficits arising will be responded to appropriately and in a timely manner.

	The centre management, staff must endeavour to update mental health and self-harm related risk management and safety plans on an ongoing basis related to specific actions and statements of young people.	the team including the protocols for checking apartments where concerns exist. As noted above, the incident reports are being updated to allow for more effective analysis of incidents. This update will also include a section for action plans and reports to update following any incidents of concern. The Centre Management team will be responsible for completing the analysis and action planning to ensure all risk management and safety plans are updated.	Senior management who reviews incident reports will oversee any deficits to updating risk assessments are actioned. Further supporting this is the monthly Regional Manager Centre meetings whereby risk assessments are reviewed and discussed.