An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 182

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Kellsgrange Residential Service**
Registered Capacity:	**One Young Person**
Type of Inspection:	**Announced Themed Inspection**
Date of inspection:	**02nd, 03rd and 09th February 2022**
Registration Status:	**Registered from the 16th November 2020 to the 16th November 2023**
Inspection Team:	**Linda McGuinness** **Joanne Cogley**
Date Report Issued:	**30th May 2022**

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 Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 16th of November 2020. 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 16th November 2020 to the 16th November 2023.

The centre's purpose and function stated that it was a single occupancy for a young person aged between thirteen to seventeen years on admission. The model of care was described as relationship based. It described the provision of a nurturing and safe environment where values of respect, honesty, consultation and individuality were promoted. Key to this was importance of working relationships between social care workers and young people within a contemporary perspective.
There was one young person 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	2.2
3: Safe Care and Support	3.1
4: Health, Wellbeing and Development	4.2
5.2 Leadership Governance and Management	5.2
6: Responsive workforce	6.1

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

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young person, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 15th March 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 centre manager returned the report with a CAPA on the 29th March 2022. Following review by inspectors the CAPA was returned to the provider on 04th April 2022 as they were not satisfied that all actions were being adequately addressed. The provider returned the CAPA again on 12th April 2022.

The findings of this inspection determined that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III Article 5: *Care Practices and Operational Policies* and Article 7: *Staffing*. A regulatory compliance meeting was held on the 04th May 2022 to review progress of required actions following the inspection.

Following this meeting it was decision of the registration committee to register this centre, ID 182 from 16th November 2020 to the 16th November 2023 with a condition attached to the centre's registration under Part VIII Article 61 (6) (a) (i) of the Child Care Act 1991. The condition being:

- There must be no further admissions of a young person to this centre until such time as the centre has suitable care practices and operational policies in place and the number, qualifications, experience and availability of members of the staff of the centre are adequate, having regard to the number of children residing in the centre and the nature of their needs.

This condition is attached from the 04th May 2022 and will be reviewed on or before the 03rd of August 2022.

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.

There was evidence the young person's voice was heard and the staff team advocated on their behalf. Inspectors found that that there was evidence that they actively participated in their day-to-day care and that their views and preferences were considered. A daily planning meeting was held where appointments, activities and meals etc. were discussed. During inspection interviews staff and management demonstrated familiarity with the complaints process and described how it was intended to work in practice.

Young people, their parents, social workers were made aware of the complaints process though written information in centre information booklets and during transition to the centre. They were also ongoing afforded opportunities to provide feedback on care provision through questionnaires and open communication. Improvements were required to evidence that action was taken on foot of information provided by the young person in their feedback. There was a clinical support professional in place and when interviewed by inspectors they stated they were not provided with information relating to complaints or other policies when they commenced employment in the centre.

The inspectors found that management and staff welcomed complaints and facilitated the young person to use the policy and procedure in place. There was evidence that they were listened to and that any complaints they made were dealt with in a timely manner. A review of the young person's care record showed that they had made sixteen complaints and all but the most recent was managed and concluded. This was under review with the supervising social work department. There was evidence that staff practice/approaches were changed upon review of a complaint that a young person made.

The complaint policy and procedure in place was generally consistent with legislation and best practice, except for using the term 'grievance' to describe complaints that were resolved locally through resolution and compromise. Grievance is a HR term and it is best practice not to be used to refer to complaints. The policy also required review as it did not set out the process by which a complaint could be made directly to Tusla for services it was responsible for delivering, using the 'Tell Us' policy.

While complaints were a standing item for discussion at team and management meetings inspectors recommend that exploration of patterns and trends is more evident on centre records. All complaints were recorded on the young person's file however the records provided no detail in relation to investigation and outcomes/resolution. The complaints register in place would not provide sufficient detail to facilitate analysis and tracking of patterns. The centre manager must also ensure that a centre complaints register is maintained rather than an individual record which will eventually be archived with the young person's file.

The young person was made aware of people external to the centre they could talk to if they had a complaint or concern about their care. Empowering People in Care (EPIC) had recently been invited the centre to meet with the young person and they were also made aware of the Ombudsman for Children.

The supervising social workers had responsibility to inform the parents about complaints/concerns about their young person's care, and it was evident that the team communicated with family members to support planning.

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 registered provider must ensure that all employees and contracted persons are provided with information relating to relevant policies and procedures during induction.
- The registered provider must ensure a full record of complaints including detail of investigation and conclusion is documented on the young person's care record. All complaints must also be held on a centre register to facilitate analysis or trend or patterns.
- The centre manager must ensure that the complaints policy is updated to remove reference to the term grievance and to include guidance to using the Tusla 'Tell Us' policy and procedure if required.
- The centre manager must ensure that there is evidence of follow up following consultation processes.

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

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

This was the first inspection onsite of this centre as the January 2021 inspection was carried out remotely due to risks associated with the Covid 19 pandemic. The young person was admitted to the centre in December 2020. Inspectors found that there had never been a care plan on file to clearly set out the needs, goals and supports required for the young person. While the centre manager wrote to the social work department on two occasions to request a care plan there was no evidence that this issue was escalated within the social work department to ensure that care planning was in line with regulations. Inspectors did not find that centre management were clear about the requirements of care planning regulations.

There was uncertainty and a lack of clarity in inspection interviews as to when a child in care review (CICR) was last held. There were two reports prepared by staff for a CIRC but no evidence on the young person's care file or centre records that one ever took place. There were no Tusla or centre minutes and no statutory care plan. It was not possible to determine if the young person or their family had input to the care planning process. A review of numerous centre audits found that inaccurate information was provided which stated that an up-to-date care plan was on file. Auditing and oversight is further discussed under standard 5.2 of this report.

Inspectors found that this case required greater oversight and input from the supervising social work department to collaborate on planning and assess care being provided.

The young person had five placement plans on file but without statutory care plans it was not possible to determine if these met all the objectives of the placement. Placement plans were not sent to the social work department for their input and agreement. Each placement plan stated that it would be updated after the next CICR. There was inaccurate and outdated information on the current plan including date of admission and current keyworkers. From review of centre documents and staff interviews, inspectors could not determine how the placement plans were updated to facilitate effective planning between child in care review meetings. Staff interviewed by the inspectors were familiar with some of the needs of the young person as set out in the plans however inspectors found that some specific areas of need were not included in placement plans. There was some evidence that the plans were discussed at team and management meetings but the internal and external auditing systems in place did not facilitate effective oversight of placement planning.

The young person had two members of the staff team assigned as keyworkers. The named people assigned to these roles changed during 2021 when there were staff changes due to staff leaving. There was a lack of evidence that placement plans were forward planning documents and that keywork and individual work was planned and co-ordinated to address specific needs. Some of the placement plans were a narrative of current issues and did not set goals for the coming month. All staff were responsible for implementing the goals of the placement plan and inspectors found that this was not effective in practice. There was a written requirement that each staff member was to complete two key working sessions per month. Inspectors found that when key working took place it was often opportunistic or in response to discussions with the young person, rather than planned and structured to address specific needs. There were only ten planned keywork sessions recorded since the start of the placement in 2020. The last planned key work report was dated 08/11/2021. There were another ten opportunity-led individual sessions recorded since admission.

Specific work targeting areas of risk and vulnerability were not specified in placement plans. With few exceptions, there was a lack of evidence that targeted key working or individual work took place following incidents of concern or risk or that these were addressed through placement planning.

Staff had not yet received training in the most recent version of model of behaviour management so had not updated the individual crisis support plan. Inspectors found that records were not adequately maintained to facilitate effective planning for the young person. For example, by cross referencing documents relating to areas of known risk, inspectors found that this did not correlate to safety plans. Also, significant information arising from individual work did not result in updates to relevant plans.

Inspectors noted that one staff member completed proactive and responsive work with the young person. However, this was recorded using a model of care from their previous employment with which neither management or staff in this centre were familiar and did not match the planning processes in this centre .

Significant improvements were required to evidence that the young person contributed to setting personal and individual goals they wished to achieve. There was one document which recorded attempts by staff to include the young person in placement planning but there was no evidence that this was followed up despite the report stating it would be reviewed again. Two of the feedback forms completed by the young person indicated that they wanted more information about their placement plan however there was no evidence of follow up with them about this matter.

There was evidence that the young person was referred to specialist services and engaged in some of these. This is further discussed under standard 4.2 of this report.

Inspectors did not find evidence that there was effective communication with the allocated social worker to ensure continuity of care and adherence to agreed decisions. A review of care files and other centre documents found that unilateral decisions were made by management and staff that were outside agreements made with the social work department and court appointed guardian ad litem (GAL). Also, there was no evidence of a risk assessment or consultation with the social work department when it was decided by centre management that a former staff member could maintain contact with the young person. The GAL informed inspectors they were also unaware of this decision and were not consulted. The social work team leader was holding the case since the last social worker left their post. They informed inspectors during post inspection interview, that unilateral decisions continued to be made by the centre manager with no consultation and little regard to the young person's safety or best interests. They had raised numerous concerns with centre management and informed inspectors that they were assured each time that all issues would be addressed. They had been on extended leave and when they returned after

Christmas, found that the issues they raised were ongoing. They stated also that staff changes were not communicated with them, they did not know a new psychotherapist had commenced work in the centre and they did not receive any reports relating to this person's work. They acknowledged that this case required more direct oversight and informed inspectors that they would be advocating for allocation of a social worker as a matter or urgency. They escalated the concerns raised during inspection to the principal social worker.

The GAL informed inspectors that they expressed their concerns in writing regarding aspects of care provision to the social work department and centre management and requested planning meetings several times since August 2021. The GAL also informed the inspectors that they did not feel that there was a comprehensive holistic plan to meet the young person's needs. For example, the Guardian ad Litem queried a significant delay in the young person accessing a specific education programme and was informed by centre management it was in process. However, when this was explored seven weeks later with the school by the GAL, the provider of this service stated they were waiting for information from the centre in a stamped addressed envelope that had not been returned, so they could not process the application. The registered provider stated that that this was posted twice but not received. Inspectors note that no report was formally made to the social work department about the young person's personal information missing in transit.

Based on interviews, correspondence and a review of centre documents inspectors concur that there are deficits in planning that require urgent and immediate attention.

Inspectors offered the young person a number of opportunities to provide feedback about their care, but they chose not to.

Staff in interviews stated they would benefit from drug and alcohol awareness, mental health and suicide awareness, self-harm and internet safety training to support the planning of care for this young person.

Compliance with Regulations	
Regulations met	**None identified**
Regulations not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Not all standards were assessed**
Practices did not meet the required standard	**Standard 2.2**

Actions required

- The registered provider must ensure that noncompliance with care planning regulations is escalated within social work departments
- The registered provider must ensure that the person in charge is fully aware of care planning regulations
- The centre manager must ensure that audits of young people's files report accurate information
- The registered provider must ensure that placement plans are sent to the social work department for their input and agreement.
- The centre manager must ensure that there is evidence that the young person contributed to setting personal and individual goals
- The registered provider supervising social work department and other professionals must work together to co-ordinate effective care for the young person. A planning meeting must be convened as a matter of priority.
- The registered provider must ensure that there are internal and external auditing systems in place to facilitate effective oversight of placement planning
- The registered provider must ensure that key work and individual work is planned, co-ordinated and implemented to address specific needs
- The registered provider must ensure that areas of known risk correlate to safety plans for the young person

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.

Inspectors found that there were recently updated policies and procedures in place which were aligned to Children First National Guidance for the Protection and Welfare of Children 2018 (Children First) and relevant legislation.

A review of personnel files or the training log provided did not show that all staff members had completed the Tusla e-learning programme Introduction to Children First. Most of the team completed training in the organisations' policies and procedures in January 2022 that included organisation's child protection policy, however this did not translate into a working knowledge of all aspects of safeguarding and child protection reporting.

The centre had a child safeguarding statement that was line with the requirements of the Children First Act, 2015. This statement was displayed in the staff office and was approved by Tusla Child Safeguarding Statement Compliance Unit. Inspectors found however, that there were deficits in working knowledge of this document at management and staff level. There was a lack of clarity about the content of the required risk assessment, and there were differing answers about who the Designated Liaison Person (DLP) and Deputy DLP was.

Inspectors found through interviews that further clarity was required in respect of reporting child protection concerns. It was indicated in interview that concerns would be brought to the attention of management/DLP who would then make a report (not a joint report). There was not absolute clarity about the responsibilities of mandated persons and that another person could not make a report on their behalf as was set out in centre policy.

Inspectors found that the DLP (the social care manager of this centre) had not received any specific training and could not fully describe the responsibilities of the role. They were not set up on the Tusla portal and relied on a manager from another centre to report child protection concerns. In one instance a child protection concern arose on 1st January 2022 when the DLP was on leave. No report was made by

mandated staff members through the Tusla Portal and there was no record of a decision not to report as required. When the DLP returned, the centre manager for another centre in the organisation made the report with the DLP named as a joint reporter. These processes were not in line with the requirements of Children First National Guidance for the Protection and Welfare of Children, 2017 or relevant legislation. The social worker for the young person was made aware that this child protection welfare referral was being made on 20th January 2022.

Within the child safeguarding policies there were policies relating to bullying, internet safety, mobile phones, working alone and a protected disclosures policy. While there was a policy and procedure on whistleblowing/protected disclosures, there was a lack of knowledge about the policy in place to report concerns about poor practice in all interviews carried out with staff and management through this inspection. Inspectors found that there was no procedure for maintaining a list of mandated persons as required.

There were other deficits in the systems in place to safeguard the young person. Inspectors found that there were unsafe recruitment practices in place. There were two policies containing information relating to safe recruitment and vetting of staff: the policy and procedures on child protection and welfare and the policy on staff employment however, these were not implemented in practice to ensure compliance with Children First section 4.5.5. This is detailed further under standard 6.1 of this report.

While there was evidence that policies and procedure were on the agenda at team meetings where staff were asked to read and sign that they understood the documents this had not translated into an adequate working knowledge for use in practice. A sample of team meetings reviewed for inspection purposes found that safeguarding, child protection was not on the standing agenda and there no evidence of discussion about these matters in the records reviewed.

There was some evidence that staff in the centre worked in partnership with the young person, their family, social workers to promote their safety however, as described above unilateral decisions were made by centre management which were not in the young person's best interests and increased risks to them and others.

The young person was offered the opportunity to speak with inspectors but chose not to. A review of feedback forms they completed in the centre indicated that they felt safe in the centre and had people they could talk to.

The organisation's policies were updated in 2021 and included an anti-bullying policy that incorporated the risk of bullying on-line and through social media platforms.

As described under standard 2.2, there was a lack of evidence of targeted specific and planned key-working sessions and more work was required to evidence that the young person was being supported to develop the skills required for self-care and protection to address identified vulnerabilities.

Inspectors were informed that the social care manager conducted monthly child protection audits and reviewed a sample of these provided. These audits were a checklist of what should be in a safeguarding statement and child protection policy/procedure and as such would not change month to month. While these audits referenced the DLP and reporting procedures that were in place, they did not assess staff knowledge of or application of policy, so the deficits identified during this inspection were not picked up. The audits did not consist of a thorough review of centre documents or care files to assess that there was adequate oversight of safeguarding in practice. This was not an effective system to ensure that the centre operated in line with Children First and relevant legislation.

Child protection was also included in a monthly centre audit completed by the centre manager under theme 3 of the National Standards. This audit consisted of generic questions which did not provide a current assessment of child protection and it did not include review of areas of individual vulnerability and safeguards in place. The centre's auditing processes require on-going development and improvement to ensure that they fully assess staff understanding of safeguarding and child protection and how policies and procedures are implemented in practice.

Inspectors found that the visitors log in place was used intermittently and did not record all visitors and the dates and times they were in the centre therefore it could not adequately support an investigation if a child protection concern arose.

The inspectors found that not all areas of individual vulnerability were identified on individual risk assessments. There was a scoring system in place to rate the presenting risks however this was not consistently applied. It was not clear what specific individual safeguards or mitigating measures were identified to respond to some of risks. Inspectors found at least three risks that should have resulted in safety plans but there was no evidence of these on the young person's record. The allocated social worker stated that there was inconsistent communication relating to the centre's assessment of risk to the young person.

Inspectors found that a serious incident of concern took place in the centre that was not managed in line with robust safeguarding and child protection policies. A professional involved in the care of the young person recorded in their report that a staff member brought their baby to the centre. They stated that they witnessed that the baby was left alone with the young person for a short period. They reported this as being inappropriate and expressed concerns for both children. Inspectors found the staff and management did not consider this as an issue and therefore did not address it. This indicated a lack of awareness of safeguarding and acceptable practices to safeguard the baby and the young person in placement.
There was no formal response to the concern raised by either the centre manager or the director of service who also received the report. The social worker and Guardian ad Litem GAL were not notified.

On the morning of inspection this professional disclosed to inspectors when interviewed, that they had been asked by the centre manager to change their report as they disagreed with the content and did not feel that there was an issue. Follow up interview with the centre manager confirmed that they did ask that the report be amended and reiterated that they felt the baby was at no risk. Inspectors found that they did not accept this and noted that this was inappropriate and that both children were vulnerable within this situation. This raised further serious concerns in respect of child protection and safeguarding in the centre. The valid concerns of another professional were not responded to and were disregarded. This person is no longer an employee of the service.

There was inadequate evidence that risk assessments were subject to regular review and monitoring to ensure the level of risk was accurately measured and to determine if mitigation measures were appropriate and reducing risk scores. Where risks to the young person change the centre manager must ensure the risk rating is increased or decreased as appropriate.

If an incident or allegation of abuse occurred for the young person in the centre, there were arrangements in place to ensure that their parents and or guardians were informed by the social work department.

There was a policy and procedure on whistleblowing/protected disclosures. From information gathered through the course of this inspection inspectors found that there was not sufficient awareness among manager and staff to ensure it would be used in practice.

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

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 3.1**

Actions required

- The registered provider must ensure that staff are fully aware of their responsibilities under Children First National Guidance for the Protection of Children 2017 including the organisations protected disclosure policy.
- The registered provider must ensure there is a system in place for effectively auditing the centre against the requirements of Children First and the national standards. There must be oversight of safeguarding in practice.
- The registered provider must ensure there is absolute clarity in the centre who the Designated Liaison Person (DLP) and Deputy Designated Liaison Person are.
- The registered provider must ensure that specific training is undertaken by the DLP and that they are fully aware of their responsibilities under Children First, National Guidance for the Protection and Welfare of Children, 2017.
- The registered provider must ensure that a maintaining a list of mandated persons is maintained in line with the requirements of Children First National Guidance for the Protection and Welfare of Children, 2017.
- The registered provider must ensure that staff and management are aware of the protected disclosures policy and how it relates to reporting concerns about poor practice.
- The registered provider must ensure that all unsafe recruitment practices cease immediately.
- The registered provider must ensure that social workers for young people are alerted when child protection welfare referrals are submitted through the Tusla Portal. Any concerns raised by other professionals must be immediately brought to the attention of the social work department.
- The registered provider must review the response to the disclosure of concern by another professional and liaise with the social work department about this

as a matter of urgency. Child protection practices in the centre must be reviewed with immediate effect.

- The registered provider must ensure that safeguarding and child protection are standing agenda items at team and management meetings
- The registered provider must ensure that the visitors log is properly maintained
- The registered provider must ensure that all areas of individual areas of vulnerability are identified risk assessed and monitored and that appropriate safeguards are in place.

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 health and development needs of the young person as specified in a care plan were not available, however inspectors could see that there was a focus on these areas through the placement plans on file.

Staff described the of the health needs of the young person and how they supported them in relation to their general health and wellbeing. They were supported to attend specialist appointments. Inspectors noted that the young person missed the opportunity to avail of the HPV vaccine as they were not in mainstream education. This should be followed up through care planning.

It was not possible to determine if specialist support was in line with the care plan. Inspectors did not find that there was a co-ordinated approach to the planning for and provision of specialist support. The GAL informed inspectors that they raised concerns that there were too many specialists involved however there was no evidence on file of exploration or discussions between all professionals about this issue. There was no evidence of strategy meetings to determine what supports were appropriate even though these were requested by the court appointed guardian ad Litem (GAL).

Notwithstanding that the young person was difficult to engage, the inspectors found that in-service psychotherapy intervention and support was not supported by effective planning to make best use of this resource. The psychotherapist was

regularly scheduled to be present in the centre on days when the young person had numerous other pre-arranged appointments. This was brought to the attention of centre management in a report prepared by the psychotherapist however there was no evidence that this was discussed in meetings to make more suitable arrangements. The centre manager confirmed in interview that this was not considered.
The employment of the psychotherapist was terminated during the inspection process.

The team facilitated the young person to engage non-directive forms therapy as it was explained this was their preference. While the young person was engaging in equine therapy there was a lack of evidence of goal setting or reports from the specialist. It was not clear from the care file how the work was therapeutic. The equine therapist did not attend planning meetings and did not provide any written updates or progress reports. The Guardian ad Litem had asked that this issue be discussed and addressed between all professionals, but this was outstanding at the time of inspection. There was confusion about what work an appointed occupational therapist was assigned to carry out. An urgent planning meeting must take place to specify needs and goals, agree these in the placement plan and identify tasks to be carried out internally and by external specialists.

Inspectors found that the team required further specific training to ensure they were confident and competent to respond effectively to some of the young person's specific health needs.

The young person was registered with general practitioner and had access to other health and medical services as required.

The staff maintained a records of all medical and specialist appointments except for the equine therapy and there was evidence that they made efforts to work closely with health care professionals.

One new recently appointed staff member took responsibility for updating medication and recording system. Records in relation to medication administration were complete and up to date. From a review of training records provided inspectors could not determine who had received training in the safe administration of medicines. Training was noted as being due in February 2022 however, no previous certificates were found on staff personnel files. Medications were stored securely in line with centre policy and unused medication was returned to the pharmacy.

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 manager and supervising social worker must ensure that the young person has access to all national immunisation programmes.
- The centre manager and supervising social worker must ensure that there is a co-ordinated approach to the planning for and provision of specialist support.
- The registered provider must ensure that specific training is provided to equip staff to respond effectively to specific needs of young people.
- The registered provider must ensure that there is a record of all specialist interventions.
- The centre manager and supervising social worker must convene a strategy meeting to determine appropriate action in respect of an issue arising relating to specialist support.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The centre had a management structure in place that consisted of a centre manager, deputy manager, three social care leaders and four social care workers. Staffing issues and non-compliance with requirements are further reported under theme 6.1 of this report.

While there was evidence that there were communication records when general tasks were delegated, there needed to be a specific record where all management specific tasks are delegated to another qualified person or persons when the manager takes periods of leave, or formally assigns some duties to another qualified person.

There was an on-call rota in place that management and staff reported was utilised effectively and working well.

Findings across the standards reviewed for this inspection found that effective leadership governance and oversight was not in place to ensure child centred safe and effective care. Inspectors found that the organisation had written governance arrangements and management structures which defined the lines of authority and accountability.

Inspectors found however, that roles and responsibilities were not adequately specified. There were no signed contracts in place and there were no job descriptions on the personnel files reviewed during inspection. As mentioned previously there was deficits in knowledge of people in leadership roles. The professional supervision of the centre manager was not adequate, and this issue was highlighted in previous inspections across the organisation.

There was a clinical governance policy in place however the procedures in place at the time of inspection were not aligned to this policy. Inspectors found there were significant deficits in respect of auditing service provision and assessment of compliance with the requirements of national standards. The people in specific roles of management and oversight did not adequately identify areas of noncompliance and put measures in place to implement appropriate action plans. Inspectors reviewed external audits completed across 2021 and found that only two audits took place. They were not aligned to the requirements of National Standards and between both they contained a brief narrative report on restrictive practice, sanctions, complaints, SEN register, medication and the physical premises. There was not an effective audit which covered child protection or safeguarding. There was no quality assurance of manager audits by the service director. Audits reviewed by inspectors indicated that staff were fully aware of the policies, procedures and all their responsibilities under safeguarding however inspectors found from interviews and centre practices that this was not accurate.

Inspectors found that audits provided inaccurate information in respect of care planning that was not highlighted or corrected through an effective quality assurance system. Inspectors were provided with six quality improvement plans for individual and specific issues arising. While these were positive, they were not embedded into an overarching quality assurance framework and require review. The systems in place did not lead to service improvement and there were repeated actions requiring attention over several inspections within the organisation. The last inspection of this service had required actions relation to auditing that were not implemented adequately. This did not demonstrate that there was a culture of learning, quality and safety within the centre and organisation. Inspectors found following inspection, during the factual accuracy process that the registered provider could not provide evidence of discussions and decisions that they said had been made at management level within the organisation.

There was an appropriate service level agreement in place and meetings took place with funding body however staffing requirements were not aligned to that stipulated in contracting.

Inspectors were provided a suite of policies that were revised and updated in 2021. Some adjustments were required to the complaints policy and the policy in respect of vetting to ensure they were fully aligned to National Standards for Children's Residential Centres, HIQA, 2018. In other areas, the procedures in the centre were in line with best practice, such as recording all complaints for tracking purposes, but the policy directed otherwise.

The system in place of maintaining registers for the young person and not the centre would not facilitate organisational learning. While pertinent information can be held on young people's care files, the registers of complaints, significant events, child protection and consequences etc should be centre registers to facilitate good governance.

There was not an adequate system to ensure proper transfer of information and to facilitate effective planning and this was not highlighted through good governance or oversight. It was noted during inspection that there was no protected time for handover and that staff were scheduled to finish at the same time as those commencing shifts. Inspectors observed that the handover on the day of inspection lasted less than 5 minutes.

Inspectors found that there were repeated deficits in respect of the identification, assessment and management of risk that were highlighted in the 2022 inspection of this service.

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

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Not all standards were assessed**
Practices did not meet the required standard	**Standard 5.2**

Actions required

- The registered provider must ensure that effective leadership governance and oversight is in place to ensure child centred safe and effective care.
- The registered provider must ensure that there is clarity in respect of roles and responsibilities. Each staff member must have a job description appropriate to their role
- The registered provider must ensure that appropriate professional supervision is provided for the centre manager to ensure professional development and accountability
- The registered provider must ensure that there is adequate auditing and assessment of compliance with the requirements of national standards and relevant legislation. There must be oversight to ensure that information contained in audits is accurate.
- The registered provider must ensure that there is prompt and full implementation of actions arising from inspection processes. Learning from inspections should be used to develop a culture of learning, quality and safety within the centre and organisation.
- The registered provider must ensure that all management meetings relating to strategic development and operational practices are appropriately recorded. Contacts and meetings with external professionals must also be recorded.
- The centre manager must ensure that appropriate centre registers are maintained at all times.

- The registered provider must ensure that there is senior management oversight of the transfer of information. There must be protected time for handover at all times to facilitate effective planning.
- The registered provider must ensure that there are appropriate systems in place for the identification, assessment and management of risk and that appropriate safety plans are implemented when required.
- The registered provider must ensure that there is a specific record where all management specific tasks are delegated to another qualified person or persons when the manager takes periods of leave, or formally assigns some duties to another qualified person.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

Through review of information provided, inspection interviews and centre records inspectors found that workforce was not planned and organised to deliver safe and effective care.

The inspectors found that Regulation 7 of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 in relation to staffing was not met at this time. There were serious deficits with recruitment and staffing and inspectors found that in respect of staff numbers, qualifications and experience the centre was found not to be in compliance with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020).

The centre was registered to commence operation in November 2020 with a staff complement of a centre manager and 8 full time (40-hour contracts) social care staff. There were at least eight changes in that core staff team since the centre was registered. Only the centre manager and two other staff remained since registration. These significant changes were not notified to the Alternative Care Inspection and Monitoring Service as requested at the time of registration. The social worker informed inspectors they were not made aware of changes on the staff team and had to query changes in the young person's keyworker and the rationale for same. At the time of inspection, the information provided indicated that there was a social care

manager, deputy manager, three social care leaders and four social care workers. One of the social care workers left at the time of inspection reducing the staff complement, outside of management, to six.

There was limited evidence of discussions at team and management meetings about ensuring that the centre always had the required staff. Inspectors found that there were only two brief periods in March and December 2021 when there was a full complement of eight staff. Upon further review of rotas and staff personnel files inspectors found that only the social care manager was contracted for 40 hours. Inspectors reviewed samples of personnel files and found that contracts were not signed and none of those reviewed specified the hours that staff were contracted to work. The deputy manager was one of the core staff and primarily worked shifts on the rota as well as some extra office hours to attend to their management duties. In total 28 people have completed shifts in the centre since it was last inspected in January 2021.

Except for one person, staff members were appropriately qualified in social care or a relevant field. This person was recruited in November 2021 subsequent to the ACIMS memo being issued to this provider, they did not hold a relevant or related qualification. They recently commenced an online course to attain a degree in health and social care and would not be qualified until May 2024 at the earliest. There was no practice element to this course. Inspectors recommend that centre management ensure that this qualification will meet the requirements to be considered a relevant qualification.

There were unsafe recruitment practices in place. Staff ~~were~~ identified to fill vacant positions ~~and~~ did not go through a formal recruitment process, and this was contrary to best practice and raised safeguarding concerns. One staff member left their post during the inspection and the registered provider informed inspectors that they would interview the next day to fill the post. This position was included in a live advertisement but there was no closing date and applicants would not have time to apply for the post prior to a person being interviewed.
In relation to one person appointed recently good and safe recruitment procedures were not followed. A formal interview not held, and references were not sought. Also, in this instance inspectors found that this person was promoted to a position of authority in the centre, subsequent to the memo being issued to this provider, and they did not hold a relevant experience for this position. Garda vetting was not sought for this person prior to taking up their position. Inspectors found gaps on their curriculum vitae (CV) that were not accounted for. All references on this file

were provided for a previous employment in the organisation. It was noted that one of these was a reference provided from an employment that was not recorded on the curriculum vitae reviewed by inspectors. Other personnel files also had gaps on curriculum vitae that were not accounted for in line with safe recruitment practice. Where interviews took place records were inadequate and inspectors could not find evidence of assessment of suitability of people for the positions.

A clinical specialist employed by the service self-reported that there was an advert for their position with no job description. They did not do an interview but attended a team meeting with the manager and director present. This person commenced employment on 11/10/21 before their Garda vetting was received on 10/12/21. Inspectors found that direct contact with the young person was allowed during this period which was a breach of safeguarding measures. Also, they did not provide copies of their qualifications during the recruitment process. This person stated they had asked for a contract since October 2021 and when they did receive one it referred to the previous person in the post. No personnel file was maintained for the psychotherapist or the maintenance person.

Inspectors reviewed team and management meetings and found that there was a focus on new staff settling in and team dynamics but workforce planning to meet the requirements of national standards and contracting obligations was not evident.

As mentioned previously, the registered provider must ensure supplementary training is provided to ensure staff were equipped to develop skills and competencies to safely meet the needs of the young person. There was a lack of evidence that behaviour management training took place in line with the expectation of the accrediting body to refresh every six months. Even allowing for extended gaps permitted due to Covid 19, training was outside frequency set in policy and the requirements for criteria of effective implementation of the model.

The registered provider must ensure that there are sufficient core staff to meet the Regulation 7 of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, the requirements of the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020) and their contractual obligations.

Notwithstanding the difficulties caused by Covid 19, inspectors found there was not adequate evidence across files reviewed during inspection to demonstrate a focus on staff retention and continuity of care.

There was a formal on call policy and procedure in place as required.

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

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 6.1**

Actions required

- The registered provider must ensure that all staff recruitment is in compliance with all aspects of the Alternative Care Inspection and Monitoring memo on staffing numbers, experience and qualifications (February 2020).
- The registered provider must ensure that the centre maintains the staffing complement which it was registered with.
- The registered provider must ensure that all recruitment is in line with the department of health circular on recruitment and selection of staff to children's residential centres.
- The registered provider must ensure that staff are provided with training in a timely manner to develop the skills and competencies to meet the needs of young people.
- The registered provider must ensure that there is evidence of a focus on staff retention and continuity of care

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The registered provider must ensure that all employees and contracted persons are provided with information relating to relevant policies and procedures during induction	Induction process to be reviewed and include more focus on policies and procedures. Any contracted/outsourced service to be given a copy of the policies by manager before commencing work. Reinduction of current employees with focus on policies. All to be complete by 30th April 2022.	Updated policies and procedures to include clause on procedure for sharing document. Template in the front of policies to record details of distribution of the document. Director has liaised with training company around including systems to test the efficacy of the instruction.
	The registered provider must ensure a full record of complaints including detail of investigation and conclusion is documented on the young person's care record. All complaints must also be held and on a centre register to facilitate analysis or trend or patterns.	Complaints system in unit to be updated to address issues outlined by 30th April 2022.	Internal auditing system to assess the updated process over the next 6 months to determine effectiveness. Request to external auditors to evaluate the procedure and provide feedback.

	The centre manager must ensure that the complaints policy is updated to remove reference to the term grievance and to include guidance to using the Tusla 'Tell Us' policy and procedure if required. The centre manager must ensure that there is evidence of follow up following consultation processes.	Complaints system in unit to be updated to address issues outlined by 30th April 2022. Tell us policy to be included in the policy. Dated terminology to be removed. Centre manager roles and responsibilities to be reiterated by director. Any record of consultation processes to include a section to record follow up and conclusion. Process to be overseen by manager and subject to external auditing processes. To be in place by 30th April 2022.	Internal auditing system to assess the updated process over the next 6 months to determine effectiveness. Request to external auditors to evaluate the procedure and provide feedback. Documentation to be assessed during director audits and external audits monthly – quarterly respectively.
2	The registered provider must ensure that noncompliance with care planning regulations is escalated within social work departments	Section is included on weekly manager/director report outlining any outstanding mandatory paperwork issues. New template to be introduced as part of monthly auditing system to make sure care/placement plans are all in order. Director to escalate any longstanding issues with obtaining requested documents to social work team leader after	Monthly overview of this system by management team will ensure no further deficits.

	The registered provider must ensure that the person in charge is fully aware of care planning regulations	one month from first request. To be in place from April 30th 2022. Management team to refresh their knowledge of care planning regulations as part of management meeting 13th April 2022. Retraining for mangers in this area to be organised with external trainers by April 30th 2022.	Immediate request to external training company from director to formulate a method to assess the training needs of managers. Training to be implemented on findings.
	The centre manager must ensure that audits of young people's files report accurate information	Manager and then director to reaudit young person's file by 13th April 2022.	Director to be cognisant of this issue when auditing files going forward.
	The registered provider must ensure that placement plans are sent to the social work department for their input and agreement.	This is to be implemented immediately and manager to be made responsible for sharing this information when updates occur. Section on weekly report to be added with dates of forwarding placement plans to relevant person.	Director to oversee weekly report record re forwarding of placement plan information and address if necessary, with manager.
	The centre manager must ensure that there is evidence that the young person	Young person to be consulted on personal and individual goals and these included on	Director/external auditing to oversee and evaluate this addition to planning process.

	contributed to setting personal and individual goals	placement plan during monthly young person's meeting. Follow up on achievements in this regard to be recorded and discussed with young person the subsequent month. Placement plans to be reviewed and subsequently updated in monthly management meeting. To be in place by April 30th 2022.	
	The registered provider supervising social work department and other professionals must work together to co-ordinate effective care for the young person. A planning meeting must be convened as a matter of priority.	Manager will request monthly scheduled professionals' meetings from all involved in the young person's care. To be recorded by the centre and a section on tasks, allocation of same and conclusion to be recorded by manager. Minutes and responsibilities to be forwarded by mail to all involved by company secretary. Planning meeting undertaken 24/02/2022. Practice to continue.	Monthly manager/director meeting to provide oversight of this process and highlight issues to be escalated by director if necessary.
	The registered provider must ensure that there are internal and external auditing systems in place to facilitate	Existing auditing systems in place internally to be reviewed by manager and director by April 30th 2022. External	Director to review auditing systems in unit in consultation with external auditors.

	effective oversight of placement planning The registered provider must ensure that key work and individual work is planned, co-ordinated and implemented to address specific needs The registered provider must ensure that areas of known risk correlate to safety plans for the young person	auditing service recommencing on 26th April 2022. Monthly keywork planning meeting to provide a monthly plan for all staff and assign specific areas of work in consultation with unit psychotherapist. Manager to oversee implementation of keywork strategy immediately. Professionals meeting scheduled for 14th April by unit manager to discuss the young persons placement and identify areas of individual work and services to support current needs. Manager to be responsible for risk management within the centre and for implementing safety plans to address such. Immediate effect.	 Ongoing monthly management meeting to assess the success and challenges of the plan and implement changes and supports where necessary. Consistent oversight and planning of risk management with weekly/monthly management meetings with internal/external auditing by director and contractors.
3	The registered provider must ensure that staff are fully aware of their responsibilities under Children First National Guidance for the Protection of Children 2017 including the	Retraining in Children First to be scheduled by April 30th 2022 for all staff. Manager to complete course. Director to discuss course content and assess	Staff competencies to be tested in recurring reinduction process in unit which is administered and overseen by the manager and subject to director auditing. Results to

	organisations protected disclosure policy.	competency with manager in monthly meeting 19th April 2022.	inform training needs analysis and further education.
	The registered provider must ensure there is a system in place for effectively auditing the centre against the requirements of Children First and the national standards. There must be oversight of safeguarding in practice.	Monthly child protection audit to be restructured to be more qualitative. This is part of the monthly internal auditing process. To be completed by May 30th 2022.	Director to continue to oversee child protection practices in the unit. Once updated child protection audit is in use director to audit monthly and return to the centre manager for actioning.
	The registered provider must ensure there is absolute clarity in the centre who the Designated Liaison Person (DLP) and Deputy Designated Liaison Person are.	Training to be undertaken by all staff in Children First. To be arranged by April 30th 2022. Staff meeting 20th April to include discussion on DLP. Manager to ensure in this meeting all staff are aware of who is responsible for these roles.	Continuous manager executed reinductions of all staff to inform ongoing training needs in this area.
	The registered provider must ensure that specific training is undertaken by the DLP and that they are fully aware of their responsibilities under Children First, National Guidance for the	DPL course to be organised for manager and deputy by 30th April 2022.	

	Protection and Welfare of Children, 2017.		
	The registered provider must ensure that a maintaining a list of mandated persons is maintained in line with the requirements of Children First National Guidance for the Protection and Welfare of Children, 2017.	In place.	Director to corroborate this list during auditing practices.
	The registered provider must ensure that staff and management are aware of the protected disclosures policy and how it relates to reporting concerns about poor practice.	Staff meeting 20th April 2022 to discuss protected disclosures policy with all staff. Manager to examine understanding in staff reinductions scheduled for May 2022.	Director to audit reinduction files ongoing to identify gaps identified in training needs.
	The registered provider must ensure that all unsafe recruitment practices cease immediately.	Recruitment policy to be adhered to. Immediate effect. Updated internal application process in place with new robust application form so all existing staff are subject to the same process as external applicants. Updated recording and scoring system in place for interviews.	Ongoing recruitment process to be overseen by director and assessed continuously by external auditors.

	The registered provider must ensure that social workers for young people are alerted when child protection welfare referrals are submitted through the Tusla Portal. Any concerns raised by other professionals must be immediately brought to the attention of the social work department.	Social Workers are informed of CPNs prior to or immediately after the submission by phone call and email.	The centre manager is responsible for reporting to the SW department and follow up of the report. The director is kept informed of the process by the manager in weekly, monthly reports until it is closed off.
	The registered provider must review the response to the disclosure of concern by another professional and liaise with the social work department about this as a matter of urgency. Child protection practices in the centre must be reviewed with immediate effect.	Completed and plan in place regarding exploration of this issue with model of care coordinator, consultant and management team.	Director instructed response to the disclosure of concern actioned. Director to oversee child protection consultation within the extended professional team. Updates and decisions in this regard will be forwarded to Tusla.
	The registered provider must ensure that safeguarding and child protection are standing agenda items at team and management meetings	Safeguarding and child protection to be discussed at each team meeting and minuted.	Director to attend staff meetings for oversight of standing agenda items.

	The registered provider must ensure that the visitors log is properly maintained The registered provider must ensure that all areas of individual vulnerability are identified risk assessed and monitored and that appropriate safeguards are in place	Manager to address this issue immediately with staff and take responsibility for the maintenance of the log. Manager to be responsible for risk management within the centre and for implementing safety plans to address such. Daily evaluation of the young person's areas of vulnerability to be undertaken by the manager in consultation with staff – this will be done at daily handover and psychotherapist input then sought. Monthly SERG meeting also to be used to identify existing areas of risk and Supports appropriate to the the presenting issue to be identified collectively and interventions actioned. Training to be implemented to support staff to deal with presenting issues/behaviours appropriately and supportively. Process to be recorded on the daily handover from 13th April 2022.	Visitors log to be subject to inspection by internal/external auditing. Ongoing oversight by director and external auditors to identify areas of risk and vulnerability.
4	The centre manager and supervising social worker must ensure that the young person has access to all national immunisation programmes.	Young person currently refusing any further vaccines. Staff to address in keywork. Manager to inform SW	Ongoing auditing to check vaccine status is recorded.

		department of the outcome and record on the young persons file for director to audit.	
	The centre manager and supervising social worker must ensure that there is a co-ordinated approach to the planning for and provision of specialist support.	Monthly professionals' meetings requested by director to all involved in young persons care 4th April 2022. Response received 7th April with meeting plan to be agreed by all in first meeting 14th April 2022.	Oversight for the provision of specialist support is with the director. Discussion on same with manager in daily, weekly, monthly meetings. Director has responsibility to ensure services are employed and funded.
	The registered provider must ensure that specific training is provided to equip staff to respond effectively to specific needs of young people.	Training needs analysis to be undertaken at monthly management meetings to identify deficits in training and to respond to current needs of the young person.	To be undertaken monthly and actioned by the director.
	The registered provider must ensure that there is a record of all specialist interventions.	Manager to establish a folder to record all specialist interventions. To be in place immediately.	Folder to be inspected by director on auditing visits.
	The centre manager and supervising social worker must convene a strategy	Manager to request same immediately from social worker.	Monthly professionals' meetings to address ongoing need for specialist supports.

	meeting to determine appropriate action in respect of an issue arising relating to specialist support		
5	The registered provider must ensure that effective leadership governance and oversight is in place to ensure child centred safe and effective care. The registered provider must ensure that there is clarity in respect of roles and responsibilities. Each staff member must have a job description appropriate to their role The registered provider must ensure that appropriate professional supervision is provided for the centre manager to ensure professional development and accountability	Restructuring of management team complete. Director oversight to continue and external auditing to be recommenced in 4-6 weeks. All job descriptions to be reissued to staff. Role clarity complete in respect of management team since restructuring in March 2022. This is in place with an external supervisor. External supervisor addresses professional development and accountability with the manager as part of the process. Director meets with supervisor weekly and gets monthly feedback from supervisor so any issues can be addressed. Monthly manager meeting with director gives opportunity to address such issues and provides accountability for both the manager and director.	Director oversight to continue and external auditing to be recommenced in 4-6 weeks. Roles and responsibilities to be incorporated as part of supervision process and revisited with staff continuously. External supervision to continue to be provided monthly for manager. Additional mentoring from this supervisor is also available on request

	The registered provider must ensure that there is adequate auditing and assessment of compliance with the requirements of national standards and relevant legislation. There must be oversight to ensure that information contained in audits is accurate.	Internal auditing to continue on a weekly/monthly basis. External auditing to be undertaken 3 times a year and focus on different themes from National Standards. Action plans from these audits to be implemented by director with the manager and then assessed by independent auditors in an agreed time limit.	3 external audits a year to be provided for the centre. External auditing to resume 26th April 2022.
	The registered provider must ensure that there is prompt and full implementation of actions arising from inspection processes. Learning from inspections should be used to develop a culture of learning, quality and safety within the centre and organisation.	Management team to assess previous inspection findings and any outstanding actions to be implemented by April 30th 2022.	Inspection findings to be included on management monthly meeting agendas to ensure all direction is implemented going forward.
	The registered provider must ensure that all management meetings relating to strategic development and operational practices are appropriately recorded. Contacts and meetings with	There are now official recorded organisational meetings monthly with managers.	This will be subject to auditing.

	external professionals must also be recorded.		
	The centre manager must ensure that appropriate centre registers are maintained at all times.	Register review to be undertaken by director and manager and issues resolved before April 30th 2022.	Registers to be audited monthly by the manager and subject to external auditing and direction.
	The registered provider must ensure that there is senior management oversight of the transfer of information. There must be protected time for handover at all times to facilitate effective planning.	Handover times changed in response to management meeting 23rd March 2022. Manager to facilitate daily handovers from 23rd March 2022.	Manager to be present and oversee all daily handovers.
	The registered provider must ensure that there are appropriate systems in place for the identification, assessment and management of risk and that appropriate safety plans are implemented when required.	Manager to be responsible for risk management within the centre and for implementing safety plans to address such. Risk management process to be evaluated with the manager and director before April 30th 2022.	Weekly, monthly reports from manager to director to provide oversight of risk management. Director responsibility to identify any deficits in the identification of risk.
	The registered provider must ensure that there is a specific record where all management specific tasks are delegated to another qualified person	Delegation log in place. System to be evaluated for efficacy by director and manager before April 30th 2022 .	New delegation system to be implemented and overseen by director

	or persons when the manager takes periods of leave, or formally assigns some duties to another qualified person.		
6	The registered provider must ensure that all staff recruitment is in compliance with all aspects of the Alternative Care Inspection and Monitoring memo on staffing numbers, experience and qualifications (February 2020).	Completed	Any changes to staffing in the centre to be reported to registration and inspection by the director.
	The registered provider must ensure that the centre maintains the staffing complement which it was registered with.	Recruitment complete for CCW position, awaiting vetting prior to start date. Staffing complement will then be met.	Director to amend contracts to extend notice periods to allow additional time for recruitment. Employee renumeration package to be explored with existing staff to determine if employee pay and benefits could be restructured to be more individualised and thus aid staff retention.
	The registered provider must ensure that all recruitment is in line with the department of health circular on recruitment and selection of staff to children's residential centres.	Acknowledged for future recruitment practices. Recruitment policy to be updated in relation to internal applications.	Director to oversee all future recruitment in line with department of health circular on recruitment and selection of staff.

	The registered provider must ensure that staff are provided with training in a timely manner to develop the skills and competencies to meet the needs of young people.	All mandatory training that was on hold due to covid is now complete. Training needs analysis to be examined monthly in relation to staff needs and presenting needs of the young person.	Training needs to be explored monthly by director and management team in unit.
	The registered provider must ensure that there is evidence of a focus on staff retention and continuity of care	Extensive renumeration package remains in place for all staff. More attention to be given at recruitment stage in relation to applicant's career plans and intention or not to remain in the residential childcare sector. Interview questions to be expanded on in this regard. Private outsourced CAST character assessment to be made available as a tool to determine the suitability of applicants for our service. Increased supervision for all staff from April 2020 staff to be supervised every 3 weeks to provide extra supports. The supervision policy has been updated to reflect this change. Change to employment contracts to extend the notice period to 1 month to give the organisation time to recruit and lessen the impact on existing staff for cover etc.	Consultation process with staff to be undertaken by managers and director on existing benefits to see can improvement be made to the existing medical, pension and holistic package for staff.