An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 188

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**24hr Care Services Residential**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**17th and 18th August 2021**
Registration Status:	**Registered from 19th February 2021 to 19th February 2024**
Inspection Team:	**Lisa Tobin** **Orla Griffin**
Date Report Issued:	**5th November, 2021**

Contents

1. Information about the inspection **4**

1.1 Centre Description
1.2 Methodology

2. Findings with regard to registration matters **7**

3. Inspection Findings **8**

3.3 Theme 3: Safe Care and Support
3.5 Theme 5: Leadership, Governance and Management

4. Corrective and Preventative Actions **20**

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 19th February 2021. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from 19th February 2021 to 19th February 2024.

The centre was registered to provide medium to long term care for four young people between the age of 13-17 years. The team worked from a trauma informed perspective identifying strengths and resiliencies for the young people. 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
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make. This was a blended inspection where part of the inspection was carried out on site and the interviews were via teleconference.

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 and to the relevant social work departments on the 5th October 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 13th October 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be 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: 188 without attached conditions from the 19th February 2021 to 19th February 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

Inspectors found that there was evidence in place to show that the safeguarding and welfare of the young people was protected and promoted. There were policies in place that addressed child protection and the welfare and safeguarding of the young people. The staff had received relevant training in child protection and completed their induction process over a two-week period. Inspectors noted from the training analysis that there were two staff members that required Children's First, 2017 training. Policies and procedures had been updated in early August 2021 in response to required action identified in an ACIMS inspection of another centre within the organisation.

Inspectors reviewed the Child Safeguarding Statement which included the associated risk assessment for the centre and the appropriate responses to minimise those risks while referencing the centre policies and procedures. At the time of the inspection, the current format was being reviewed by Tusla Child Safeguarding Statement Compliance Unit for approval. There were six risks identified addressing the risk of harm from others: staff and peers, accidents, trips away, family access and the risk of online bullying/using the internet. Procedures were identified around the safeguarding of those risks. The designated liaison person was identified as the centre manager who had completed the relevant training for the role. The deputy designated liaison person was identified as the deputy manager, however, did not have the relevant training.

There was a register for recording child protection concerns, there were currently five entries opened. Four of these related to an ex-resident and the centre management had requested closure letters from the relevant social worker for the ex-resident. Inspectors were informed during interview with the other social worker that the opened child protection notification had been closed. There was a reporting procedure in place in conjunction with the social work department regarding new child protection concerns. The social worker would receive an individual work form

with the details of the disclosure and would then inform the team if this was new or old information. Once identified as new information, the team would report the concern through the Tusla portal. This process was not in line with Children's First 2017. Where delays were identified, there was no escalation process in place to raise theses.

There was a bullying policy in place in the centre and bullying was not identified as a concern due to the current single occupancy, however, to ensure oversight within the centre bullying was now a standard item on the agenda for the managers weekly report. The staff were aware of the safeguarding policies and procedures when interviewed and demonstrated a good working knowledge of the procedures for reporting the current young person's child protection welfare report forms.

Inspectors reviewed documents which showed the support given to the young person regarding promoting their safety and wellbeing through key working and individual work. Inspectors saw evidence of contact with family and the allocated social worker regarding any safety and wellbeing concerns of the young person. There were clear systems in place to manage family contact, with good communication between the Tusla Social Work Department and the Children's Residential Centre and in consultation with the young person and with regular review.

There was an independent living skills programme in place to support young people in preparing for aftercare. The young person participated in young people meetings where they voiced their concerns if required. It was noted by inspectors when completing the file review that the young person voiced issues regarding the level of interaction/engagement with the Tusla social work department. The inspectors saw the issue was addressed with the young person through individual work with the staff and with a meeting with the social work team leader, however, there was no record of this in the internal/external complaints section which would have shown the complaint, actions taken, the outcome and the feedback from the young person. The young person had received information about Tell US but did not use that process on this occasion.

The young person was supported around addressing their self-awareness and self-care and protection. There were individual risk assessments and an individual crisis support plan (ICSP) in place for the young person which identified areas of risk and how staff can manage to reduce risk. As it was a relatively new admission, the staff were working on building relationships with the young person and added new information to the ICSP as it became apparent. In reviewing the ex-resident's files,

inspectors saw a higher level of risk assessments due to the challenging behaviours of the young person. The risk assessments were reviewed regularly and overseen by management.

The centre had a good communication system in place for parents to be informed of significant events and agreement for communication from the social work department regarding any child protection matters. Incidents were written up by the staff on shift and management comments were added. These reports were noted as being sent promptly to social workers. There was a reporting structure in place for the child protection welfare report forms.

There was a policy and procedure on protected disclosures in place. When interviewing staff and reviewing staff questionnaires, they were aware of the policy and of the reasons that may lead them to make a protected disclosure. The staff expressed confidence in using the policy should the need arise. Currently, there were no protected disclosures made in the centre. The staff were aware who they would report the disclosure to and named the centre manager as the DLP, however the staff require a clearer understanding on who to report to in the centre managers' absence or if the issue was about the manager.

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

There were policies in place regarding management of behaviour and challenging behaviour that were linked to the National Standards for Children's Residential Centres, 2018 (HIQA). Staff interviewed were aware of the policies linked to managing behaviours and referenced their training in a recognised model of behaviour management. On review of the training schedule, dates for training four new staff were scheduled in this recognised model of behaviour management. This was identified in the centre risk register. The staff requiring the training were newly appointed and dates had been set for their training. The staff were trained in the centre policies during their two-week induction.

Inspectors reviewed several documents which were available for the staff to reference in guiding them with the behaviour management of the young people. These included Identification, Assessment and Management of Risk (IAMR), ICSP's, IAMP's, care approaches and individual risk assessments. The IAMR document was like the format of the pre-admission risk assessment and was updated every two weeks. There was a risk matrix attached to a scoring system. This was a good way for

the staff and management to oversee changes in risk behaviours, add any new risk and act on them, however inspectors found that in one instance the risk rating was not reviewed and increased following a serious incident in the centre.

On reviewing the ICSP's for the young person, inspectors noted that the staff were gathering new information about the young person's behaviours, however there was a lack of guidance in how the staff were to respond and manage the young person's behaviours. Requests had been made to a previous placement for the ICSP which had not been received.

The organisation's policy on physical restraint sets out the requirements for the ICSP to contain information about the contraindicators and use of restraint should a physical intervention be required. However, inspectors found that this information was not part of the ICSP on the child's file and management were informed of their requirement to act on this. The ICSP's were overseen by the key worker and signed by the centre manager. Inspectors noted that there was oversight from the organisation's psychologist for some of the risk documents however it was unclear to inspectors what overall input the psychologist had with the young people. The young people were involved in the development of or were consulted about their plans in place regarding their behaviour management. There were individual risk assessments alongside a risk assessment book in place for an ex-resident which referenced one off, new, or extreme changes in behaviours such as the level of substance misuse, property damage and threatening behaviour towards the staff. Therapeutic plans for the previous resident evidenced that specialist supports were in place or being sought to support the young person's complex needs. There was a placement support plan for the new resident and a therapeutic plan will be created in the coming weeks.

The staff used their relationship with the young people and their knowledge of the young people's history to help de-escalate challenging behaviours. The organisation was in the process of training all staff in a new model of care which was a trauma informed care practice. This model of care identifies the needs of the young people and the appropriate responses from staff considering the past traumas endured by the young people. The staff showed awareness of the young people's mental health and identified that past incidents may have impacted their current behaviours.

Inspectors noted that the ex-resident had several sanctions in place that were monetary based. After a review of the behaviours and sanctions, it was decided that this approach was not effective, and the team moved to a more positive behaviour

reward-based approach. This appeared to be more effective with the young person and staff reported an improvement in behaviour for a period.

During staff interviews it was highlighted that relevant information was received from the Tusla National Placement Planning Team and from the allocated social workers about the young person's behaviour that may challenge. There was evidence that this information was reviewed regularly and reassessed by the staff team. The team were looking into supports around educating themselves further in cultural identities to assist in working with the new resident.

There was a system in place for auditing behaviours that challenge through the significant event review group. The young people's behaviours were discussed at team meetings, significant event review groups (SERG's) and at senior management meetings. The SERG meetings included members of the clinical team and the managers from the centres and higher management. Behaviours were discussed and actions were identified which the team were informed of. There was evidence of learning for the team from the placement that broke down. Reflection work was carried out with the team which identified areas for change and things to plan for with future placements.

The current restrictive practice policy was reviewed following a recent inspection within the organisation. Inspectors were informed that there were currently no restrictive practices in place in the centre, however inspectors were aware of bedroom door alarms and window restrictors in place. Inspectors discussed with staff what would be deemed a restrictive practice and they were aware of what a restriction would be. Further discussion around identifying what specific restrictions could be placed in the centre would be beneficial for team learning and should be reviewed by the team.

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

The organisation had policies on significant events, SERG's and shift debrief which guided the team in their management of incidents. Staff spoke during interviews about the supports they receive through supervision, team meetings, clinical input and ongoing training. An open culture was promoted with the young people in the centre as they were made aware of their rights, the complaints process and how to raise any concerns they have during individual work, key working and while participating in young people's meetings. The young people were also provided with

a young person's booklet which outlined the relevant aspects of the service and included the complaints process.

There was evidence of the mechanisms in place for parents, social workers and guardians to be involved in the young people's lives. The staff had regular contact with family members and social workers where feedback was given on all aspects of the young person's care. Families and social workers were promptly informed of any incidents that occurred, were involved in relevant decision making and were invited to part take in the review meetings of the young people. The allocated social worker stated that they provided feedback to the team in all matters concerning the young people. The staff sent individual work reports, key working reports and child protection welfare reports to the social worker which informed them of the support given to the young people and the areas for further development.

Significant events were reviewed at team meetings, during supervisions and debriefs. The incidents were reviewed by senior management with comments added and at SERG meetings where trends were looked at, outcomes were created for the team or the young people, and learnings were discussed at an organisational level. The team were subsequently informed of the outcomes at team meetings. Inspectors noted that SERG meetings were held quarterly. For the ex-resident, incidents occurred regularly and at times increased in severity. It may have been beneficial for the management team to have met more regularly to discuss the ex-resident's behaviours at SERG to establish any needs for the young person or the team in a quicker timeframe. The SERG had identified issues of substance misuse for the ex-resident. A referral for support had been made but due to the cyber-attack, this did not materialise, however inspectors did not note any other intervention taking place to address the drug use during the placement. Alternative options should have been looked at to address this ongoing issue.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The centre manager must ensure that all staff complete the relevant mandatory training in particular Children's first and recognised model of behaviour management.
- The centre manager must ensure that any complaints made by the young people were recorded, responded to, and reviewed.
- The centre manager must ensure that the risk management documents are updated in response to new or escalating behaviours.
- The centre manager must ensure ICSP's have all the appropriate information for staff to manage the behaviours of the young people and the correct information around appropriate physical interventions as per centre policy.

Regulation 5: Care Practice s and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The service manager, centre manager and staff team had a governance structure in place which showed that the centre was operating in compliance with the requirement of relevant legislation, regulations, and National Standards for Children's Residential Centres, 2018 (HIQA). The centre manager was responsible for ensuring any new or existing legislation was implemented as required to ensure there was no gaps in compliance.

There was evidence of the centre manager and the staff's knowledge of the regulations and standards from the interviews undertaken and the questionnaires reviewed. Inspectors noted that the policies were being reviewed and refreshed with the team through a quiz which the team identified as very beneficial and showed a creative approach around the team development. On review of the team meeting minutes it was identified that further information on what policies had been discussed at team meetings should be documented in the minutes to show the work that was completed.

Inspectors reviewed an audit completed in August 2021 by the service manager against themes 1,2,3 and 4 against the National Standards for Children's Residential Centres, 2018 (HIQA). There were actions attached which outlined where the deficits lay. The audit report indicated whether the standard was found to be met/partially met/ not met and the inspectors found there was a lack of qualitative information to substantiate the findings of the audit. There was information from interviews with the young person and with the staff also attached to the audit completed which gave further feedback for the service manager. As the centre was opened in February 2021, there were no other external audits available to review. Inspectors reviewed a file audit carried out by staff on the young person's files which went through the 16 sections and addressed outstanding reports required or where follow up was needed. The internal audits against the national standards had not yet commenced however inspectors were shown the template which the centre manager stated would be used.

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.

Leadership was evident to inspectors from the centre manager and the two deputy managers in the centre through their oversight of paperwork, supervision and leading the team meetings. The management team met weekly for a planning meeting and identified any areas of work or support required which was delegated out between them. There were detailed minutes kept of these meetings which outlined the action plans for the coming week. Staff highlighted during interviews and through questionnaires that they were supported by the management in the centre, and this was not only during supervision and debriefs, but in general when on shift. Staff reported the management team were approachable and staff stated they felt listened to when they would give their opinion or suggestions for training/development. The Tusla social worker gave positive feedback on the experience of interaction with management and the team.

Inspectors noted while reviewing the young people's files that there was oversight from all levels within the service from the director level to social care worker across the centre records. Staff were aware of the organisational structure and the roles and responsibilities held by the relevant people. There were clearly defined governance arrangements and structures which outlined the authority and accountability for the centre.

The registered proprietor had a service level agreement in place with the funding body Tusla, The Child and Family Agency. Six monthly reports were required to be sent to Tusla in due course showing the centres commitments were being upheld as per agreement in place. The centre manager had overall accountability for the centre. There was a clear understanding of the role and responsibility which was evident in the documents reviewed.

The organisation's policies and procedures were updated in August 2021 in response to required actions identified from an ACIMS inspection of another centre within the organisation. Policies were updated yearly or as required. Policies were discussed at team meetings, weekly management planning meetings and at senior management meetings.

There was a risk management framework in place which included preadmission risk assessments (PARA), identification, assessment, and management of risk (IAMR), individual risk assessments and absent management plans (AMPs) for the young people. There was a policy in place for the use of IAMR's and there were policies and procedures for reporting young people missing from care.

There was a centre risk register in place however this required further development as there were many risks present in the centre that had not been identified on the risk register, such as security risks due to unknown visitors on the centre grounds and safety risk to the staff due to level of violence and aggression. There was no organisational risk register in place. The service manager discussed plans with the inspectors about the content of the organisational risk register and stated one would be developed. There was no escalation policy or procedure in place regarding the management of risk or oversight of any possible internal or external risk that would require a response from senior management or Tusla. This should form part of the risk management framework and ensure accountability in the process. Inspectors noted that the PARA had a total score at the end of the report however, there was no reference point to whether a placement would proceed based on the score achieved.

There was an organisational structure in place appropriate to the size of the organisation. The deputy manager acted up in the absence of the centre manager. The deputy manager showed leadership in managing the centre for an extended period when the centre manager was absent. There was evidence of leadership from the deputy managers through oversight of the paperwork, supervisions and leading of

team meetings. There was a written format for the delegation of tasks to staff when needed.

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

There was a statement of purpose in place for the centre which outlined the most relevant aspects of the service. The centre provided a service for up to four young people aged 13-17 years for medium to long term placements. The statement was available to the staff team in the office and a version was available for family members. Model of care training was currently being undertaken by the team and will be completed by the end of September 2021. The statement of purpose and function was reviewed in August 2021 following a previous inspection within the organisation. The statement outlined that the next review was to take place on 1st August 2021 and had not been updated with a new review date. Further information about the chosen model of care would be beneficial in the statement of purpose and function once the training was completed by the team. The statement did not identify the numbers of staff that worked in the centre. The statement did not mention the clinical involvement which was utilised regularly and was a positive resource to have.

Staff informed inspectors that they undertake a trauma informed care response to the young people they worked with and were looking forward to implementing the new model of care with the whole team in the coming month. Social workers were aware of the statement of purpose and function. The young person's booklet identified information that was relevant to the statement of purpose and function.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

The quality, safety, and continuity of care of the young people was reviewed regularly within the centre through personal support plans, team meetings, supervision with the staff, discussion during handover's and in reviewing the risk assessments in place. There was evidence of oversight from senior management through their sign off on documents however, it was advised that dates should be attached to any sign off by senior management to evidence oversight.

The service manager had carried out an external audit against the National Standards for Children's Residential Centres, 2018 (HIQA) on themes 1,2,3 and 4 to date and stated the next audit would encompass the remaining themes, as the centre was only in operation since February 2021. Included in the audit was an oversight of actions required by the centre in which the centre management team were taking responsibility in completing the relevant actions.

Senior management meeting minutes were reviewed by inspectors which discussed issues relating to the organisation and the specific centres. There was oversight of complaints, incidents and concerns at these meetings and further plans put in place to address these. SERG reviews were planned in which clinical support was available to address any actions that could have been taken or to help identify any learning that could be brought back to the team. Significant events were reviewed at team meetings, supervisions and during debriefs. Inspectors reviewed the complaints register which had no records entered to date. As stated in this report, management must take action to ensure that complaints raised by a young person in response to interaction/engagement with the social work department are managed through their complaints policy and by using or facilitating the young person in using Tusla Tell US to address the complaint.

The senior management meeting minutes showed the management discussed the discharge of young people and acknowledged the learning from the placement. The identifying reasons for discharge were due to high levels of aggression, property damage, poly substance misuse and safety concerns. On reviewing the PARA for the ex-resident, all the above issues were identified as high risk 42/42 which were known to the organisation. The ex-residents engagement in poly substance misuse was seen as a contributing factor to the discharge, however, external supports were not available to the young person due to paperwork being mislaid by the external service where an application had been made in April 2021. Inspectors noted that staff attempted to contact the service to query the status of the application however, inspectors did not note any alternative support services being identified or explored in the interim to help support the ex-resident with the ongoing issues.

An annual review of compliance for the organisation was currently being undertaken by the regional manager who stated it would be completed by the end of August 2021.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 5.1**
Practices met the required standard in some respects only	**Standard 5.2** **Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure the centre risk register identifies all risks present and includes how staff respond to those risks.
- The regional manager and centre manager must ensure an organisational risk registered is developed.
- The centre manager must review the total scoring on PARA and use the information to identify if the centre can cater for the needs of the young person.
- The centre manager must ensure all relevant information was included in the statement of purpose and function.
- The centre manager must explore all options to support the young people with addressing their goals and presenting behaviours.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure that all staff complete the relevant mandatory training in particular Children's first and recognised model of behaviour management.	The two staff that were outstanding were trained along with updated training for the wider staff team in Children's First over the 13th/14th and 15th of August. The wider staff team have all been trained in our Trauma Informed Model of Care as per schedule. The last group were trained on September 16 and 17th 2021. All staff have identified training dates in TCI.	The Acting Service Manager along with the Training Instructors will ensure that the teams identified training needs on appointment will be addressed in a timely manner.
	The centre manager must ensure that any complaints made by the young people were recorded, responded to and reviewed.	Following discussion with Lead Inspector about this complaint being eligible for the Tell Us Policy and the reluctance of a young person to follow this route we recorded this in our Internal Complaints system and that has been dealt with accordingly.	The Acting Service Manager will ensure that the management team are confident in recording complaints and how we manage complaints against service etc outside of the organisation as opposed to only using the complaints system as a method of tracking complaints within our organisation.
	The centre manager must ensure that	We have a complete critical review of our	

	the risk management documents are updated in response to new or escalating behaviours.	Preadmission Risk Assessment and our IAMR following discussions on this. We have agreed that as part of the case management process that Risk ratings are critically reviewed every six weeks. We had already had a system in place to discuss risk within the Placement Support Plans and the Senior Management team are supporting Managers to ensure that this is being utilised effectively. The Centre Managers and teams have a better understanding of the risk rating system following this inspection which will show more confidence and governance over the management of risk	The Acting Service Manager will ensure that all Managers are regularly reviewing and updating risk management documents as part of general governance, attending Case Management meetings and through the external auditing process. Keyworkers will be heavily involved in this process to promote confidence. We will also ensure to discuss in detail about the Risk Management Framework at our Monthly Managers Meetings
	The centre manager must ensure ICSP's have all the appropriate information for staff to manage the behaviours of the young people and the correct information around appropriate physical interventions as per centre policy	This created huge learning across the service and all ICSP's have had an organisational review by Senior Managers and centre managers. All ICSP's highlight physical intervention as per centre policy	The Acting Service Manager will ensure that all Managers are regularly reviewing and updating ICSP's, risk management documents as part of general governance, attending Case Management meetings, critical reviews of these documents at SERG's and through the external auditing process.

5	The centre manager must ensure the centre risk register identifies all risks present and includes how staff respond to those risks.	While we do have a centre risk register – as per email sent on the 12th of August, we did not in the first instance name it as that – however named it as a Risk Assessment. In the second instance we omitted COVID – as we have a separate, lengthy COVID Risk Management Plan. We have however identified COVID as a Risk now. We have also updated the document to include unwelcome visitors to the centre. What was provided to the Inspectors was a register of action that needed to be undertaken following a review of the Risk Assessments that are completed monthly by Team Leaders	The Acting Service Manager will ensure that documents that we have are named in respect of the new National Standards. During Inspections, the Inspector will be provided with the Risk Register rather than a register of identified issues that need action. As we are reviewing some paperwork on November 30th, we have added this document for review across the service and will be looking for feedback from the teams.
	The regional manager and centre manager must ensure an organisational risk registered is developed.	This has been developed	We will review this as identified in the document
	The centre manager must review the total scoring on PARA and use the information to identify if the centre can cater for the needs of the young person.	We have had a complete review of our Preadmission Risk Assessment We have removed the scoring completely as the scoring was merely highlighting the identified pieces of work that would direct	We have identified a date of December 15th to Review the current system, ensure effectiveness and make any necessary changes to the system if necessary.

		our work with young people. We have agreed that as part of the case management process that Risk's ratings are critically reviewed every six weeks which will identify if the identified strategies are working for that young person or if we need to amend them to supporting adapting our approaches	
	The centre manager must ensure all relevant information was included in the statement of purpose and function.	This has been updated.	As we have a review of Model of Care in November, we will review our statement of Purpose within this.
	The centre manager must explore all options to support the young people with addressing their goals and presenting behaviours.	While we have recorded plans and actions that we undertook to liaise with a drug service to work with the team on how best to respond and how to work with the young person in a Harm Reduction Approach while we waited for Intervention. This did happen on July 1st at our Team Meeting however our young person had been discharged at this stage, we have taken this learning on and issues like this are highlighted through the new Case Management process which the	The Acting Service Manager will ensure that all Managers are regularly reviewing and updating risk management documents as part of general governance, attending Case Management meetings and through the external auditing process and identifying shortfalls in access to services. The Acting Service Manager will ensure to record all discussions around same and clear efforts made to address any presenting needs.

		Acting Service Manager attends on occasion. This supports the management team at each house in identifying any potential shortfalls	