An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 198

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Attuned Programmes Ireland Ltd.**
Registered Capacity:	**Single Occupancy**
Type of Inspection:	**Unannounced**
Date of inspection:	**15th, 16th and 17th January 2024**
Registration Status:	**Registered from 03rd August 2021 to 03rd August 2024**
Inspection Team:	**Ciara Nangle** **Sinead Tierney**
Date Report Issued:	**17th May 2024**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 03rd August 2021. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from the 03rd August 2021 to the 03rd August 2024.

The centre was registered to provide single occupancy care for one young person from age thirteen to seventeen years on admission. The model of care strived to meet young people "where they are at" and accepts that each young person as doing the very best they can, given the current resources (intrinsic and extrinsic) at their disposal. The approach was influenced by the principals of Gestalt Psychotherapy which offered a holistic view that people are intricately linked to and influenced by their environments and that all people strive towards growth and balance. Young people were provided with opportunities to develop relationships with caring adults who role model appropriate ways of dealing with emotions, life challenges and day to day lived experiences in a lived environment. 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
2: Effective Care and Support	2.3
3: Safe Care and Support	3.1
5: 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 6th March 2024. 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 21st March 2024. This was deemed to be not satisfactory and an updated CAPA was received by the inspection service on the 17th April 2024. The CAPA was reviewed and all non- compliance with regulatory matters identified in the report have now been addressed to the satisfaction of the Alternative Care Inspection and Monitoring Service and the relevant regulations now deemed to be met.

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: 198 without attached conditions from the 03rd August 2021 to the 03rd August 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The centre was of adequate size and had a suitable layout to provide care for one young person. The centre was warm and bright with significant natural light in the open plan living area. The centre was nicely decorated however further soft furnishing could make it more homely for the young person. There was building work going on at the time of inspection to increase the size of the centre. This was fenced off from the main house which limited access to the building works. The outside of the house and surrounding grounds were well maintained. There was age-appropriate recreational activities for the young person within the centre and the young person was encouraged to develop their hobbies and interests and had access to the required equipment to develop these hobbies. The centre had appropriate insurance cover in place.

The young person had a sizeable room with adequate storage for their belongings. The room had a large ensuite so the young person had their own bathroom. On the day of inspection the young person's room did not appear to have been cleaned in a number of weeks and there was rubbish and used kitchen wear in the room. This was in circumstances where the young person had been absent from the centre for an extended period and the room had been vacant and available to be cleaned.

The centre had a cleaning schedule and check list in place aligned to the organisations policies around household maintenance. On review of this document, inspectors found that the checklist was being completed by staff however it was not reflective of the cleaning being undertaken within the house as observed by inspectors. At times, tasks were ticked as being completed however they had not been. There was no evidence of management oversight on the check list and as such

the mis recording of information had not been identified as an issue. Additionally, management had not checked the young person's bedroom to ensure it was clean and ready for his return to the centre or ensured that the team had completed these tasks.

The centre had two centre vehicles that staff used in transporting young people. Safety checks were completed on a scheduled basis by the staff team on the vehicles. These checks involved a checklist that staff completed. Again, information was not accurately being recorded within these checklists nor were they always being completed in the timeframes required. Inspectors identified that one car had no NCT certificate displayed however this was not always highlighted during the checks and even when it had been highlighted the issue wasn't addressed. Additionally, there was no tax disc displayed in one of the cars for over 9 months with the issue only being rectified in the days prior to inspection. This again was not always highlighted within the checks completed and as such appropriate follow up was not completed. Inspectors also noted from observation of the vehicles that the tyres on one of the vehicles were very obviously worn and threadbare however again this had not been highlighted within the safety checks despite the types being recorded as being regularly checked. There was no evidence of management oversight on these car checks.

The centre only had three licenced drivers on the team. It was not always possible to have a driver on shift and given the remote location of the centre it was not always possible for the staff and young person to leave the centre. While efforts were made to ensure there was always a driver on shift to support the young person this was not always possible. There was no clear plan for staff identifying how to respond or leave the centre in the event of an emergency if there was no driver available and this would be beneficial to ensure there was no adverse impact on the young person in the event of a driver not being available. The social work team had also raised this issue with the centre and advised that there was a need for a driver to be available to the young person.

The centre had an appropriate fire alarm system in place. There was a schedule of fire safety checks completed periodically and these were recorded within the fire register. On the day of inspection, inspectors identified four fire doors that were not functioning appropriately; however, these had not been identified within the fire safety checks that had been completed by the team. Not all staff had participated in a fire drill within the centre, and it was recorded that a fire drill for the young person was completed in January 2024, despite the young person being missing from the

centre at that time so could not participate. Not all staff were trained in fire safety and there was no appropriate risk assessment in place to reflect this.

There was a maintenance log in place within the centre however this was not being used to record maintenance requests and the centre manager was not aware that it was in operation. Inspectors noted some requests recorded in the communication book, and staff and management reported that maintenance requests tended to be submitted via e-mail. While staff reported that requests were addressed promptly, inspectors noted that the intercom for the gate remained broken since at least July 2023 and inspectors could not track actions taken to address this. There were also window alarms broken in the young person's bedroom and inspectors could not find records of this being raised as an issue to be addressed. In the absence of these requests being recorded in a consistent manner, inspectors could not track if maintenance of the centre was being managed appropriately.

There had been no accidents reported for the current resident. Staff in interview outlined the process they would follow should an accident occur and identified where it would be recorded. In interview the centre manager was unclear on the procedure that would be followed if there was an accident. Further work with the centre management and team is required to ensure that a consistent approach is taken to the management, reporting and recording of accidents within the centre.

There was a health and safety statement in place for the centre which had been discussed at the most recent staff team meeting in January 2024. This document was not dated and as such inspectors could not identify when this was developed. This was available for the team to review and sign that they had read. Within this document it identified that a number of staff had first aid training, however on review of training registers provided during the inspection only one member of the team was trained. The health and safety statement did not identify those with specific roles e.g. the health and safety officer or the fire officer.

The centre had an emergency response plan in place which was available to staff in the Health and Safety folder. This designated the registered provider as the emergency contact however the number recorded was no longer in service and this required updating. There were a number of risk assessments in relation to the house in place which had been updated in January 2024. However, the actions to mitigate the identified risks were not sufficient and improvement is required. There was no health and safety audits on file.

Overall inspectors found that the records maintained by the centre in relation to health and safety, fire and maintenance were not accurate. At times the records contained incorrect information, they were not reflective of the presenting issues in the centre and there was a lack of oversight from management on these records to ensure that they were accurate. This is an issue that was present in various other records maintained within the centre which is detailed further in the subsequent sections of this report. This requires immediate improvement.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15**
Regulation not met	**Regulation 17**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed under this theme**
Practices met the required standard in some respects only	**Not all standards were assessed under this theme**
Practices did not meet the required standard	**Standard 2.3**

Actions required

- The centre manager must ensure that records maintained by the centre are accurate and a true reflection of work undertaken.
- The centre manager must ensure that there is oversight from management of records maintained and this is evidenced throughout these records.
- The centre manager must ensure that the vehicles available for the young person are roadworthy and comply with all legal requirements.
- The centre manager must ensure that the centre is cleaned and maintained to an appropriate standard.
- The centre manager must ensure that all staff are appropriately trained in fire safety and participate in a fire drill.
- The centre manager must ensure that the fire doors are effective and in working order.
- The centre manager must ensure that there are clear records of maintenance requests inclusive of timeframes.

- The registered provider must ensure that the centre manager and team are aware of the procedures for recording and reporting accidents within the centre.

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.

The organisation had policies and procedures in place which were aligned to children's first and other relevant legislation. Within these policies it set out requirements for staff recruitment, vetting and practices to ensure safe care for children and young people accessing the services. While these policies were in place, they were not always adhered to. At the time of inspection, one staff members Garda Vetting had not been reviewed since October 2023 which was not aligned to the policies and procedures in place and a second member of the teams vetting was due to expire at the end of January 2024 without updated vetting being processed. There was a mechanism in place within the organisation to notify the staff member when updated vetting was required. While inspectors reviewed documentation reminding the team members of the need to update their vetting, there was not sufficient follow up or accountability when no action was taken by the staff member. The centre manager and head of services informed inspectors they were not aware that one staff member did not have current vetting and therefore had not risk assessed or implemented the appropriate safeguards for this situation.

A number of the team did not have up to date mandatory trainings as set out in the organisations policies. Some staff did not have up to date Children's First training. No additional child protection training in the centres child protection policies and procedures had been provided to the team. Child Sexual Exploitation training for the team had not been considered by the centre management and a number of the team had not completed mandated person's training. The absence of mandatory trainings had been risk assessed in January 2024, however the risk had been evident for months prior to this and there was no identified plan in place to address this. Additionally, it was difficult to ascertain who had completed trainings as certificates of completion were stored in a variety of places within the centre and head office with no clear mechanism in place for oversight and tracking of this.

The centre implemented risk assessments and safety plans in relation to the vetting of the two staff member and the completion of Children's First training in the week following the inspection. Ongoing and effective tracking and monitoring of staff vetting and training is required to ensure the organisations policies are adhered to, National Standards for Residential Care 2018 (HIQA) are met and safe care for the young people accessing the service is provided.

Team members interviewed were aware of the procedures around reporting a child protection and welfare report (CPWRF) and could identify the Designated Liaison Person (DLP) for the centre. On review of records, CPWRF's appeared to be identified and reported appropriately and by both staff and management.

The centre had policies in place in regard to bullying and there was no documented evidence to suggest that bullying was an issue at the time of inspection.

There was a child safeguarding statement in place within the centre. This identified potential risks to the young people placed in the centre and identified the controls in place to mitigate these risks. It outlined who the DLP was for the centre and the Deputy DLP. The statement had recently been discussed with the team during a team meeting and they were asked to read and sign to evidence they had reviewed it. However, in interview the centre manager and one staff member weren't familiar with its contents or what the risks identified were.

While the staff team and management spoke about a collective approach to the care of the young person in the centre, inspectors did not see records from meetings that took place with the other professionals working with this young person to evidence this collective approach. The social worker for the young person regularly sent summary emails after phone calls to the team of actions agreed to ensure that there was a shared understanding of discussions held and actions agreed. The social worker advised inspector in interview that at times there was difficulty receiving information from the centre and on occasion there was inconsistent information communicated to the young person. As the records maintained in the files were limited, it was difficult to track the rational for certain decisions and the actions taken in response to issues arising or planning for the young person.

There was regular contact with the young person's family members, particularly over the previous 3 to 4 weeks as the young person had been absent from the centre. This contact was recorded across daily logs and contact records. At times however,

information was not consistent across both, with additional information recorded within the logs only. This requires improvement to ensure that records are consistent and accurate.

The young person was not present in the centre during the inspection and due to the discrepancies in recording of information within the documents reviewed, inspectors were unable to determine if the young person remained reported as a missing child from care (MCFC). Different information was recorded in different records. In interview with the staff team and management, there was a belief that the young person was no longer reported missing in care as there was an awareness of where the young person was. There was a reference to this in a January team meeting but neither the team or management were confident about what the young persons status was. Inspectors could not ascertain why this information had not been clarified with An Garda Siochana (AGS). At the request of inspectors, the centre received clarity from the AGS that there was no active report on the system for the young person. Given the lack of awareness of this within the centre, additional safeguards had not been implemented to safeguard or plan for the young person.

Additionally, the centre was not using the correct form to report the young person missing from care. The report form provided within the Missing from Care Joint Protocol must be utilised. The registered provider must ensure that the staff team are aware of the '*Children Missing from Care, A joint Protocol between An Garda Síochána and the Health Service Executive, Children and Family Services'* 2012, its associated reporting forms and its effective implementation.

Given the young person had been absent from the centre for an extended period and their placement had only commenced in the months prior to inspection, there had been limited individual work completed to support them in keeping themselves safe. In interview staff struggled to identify what work was being undertaken to support the young person safeguarding themselves. Staff identified that daily contact was being made to safeguard this young person, however on review of the records, these conversations were brief and offered minimal support in terms of safeguarding this young person. The team had made some attempts to meet with the young person however had not been successful. Additionally, at times it was recorded that the young person had not stayed with family overnight, however inspectors could not determine the centre's response to these situations or that they were clarify that he was with family each night.

Records, such as the young person's placement plans, absent management plan, safety plan, risk assessments etc had not been updated as required. Within the placement plan there was no person assigned for follow up on tasks and timeframes were not included and risk assessments were not reviewed as indicated and updated to reflect current risks.

The current risk of being missing in care was not reflected within these documents and this requires immediate improvement to ensure that staff can access up to date documentation to inform their practices with this young person.

There was an awareness amongst the team how to respond to and report a concern in relation to staff practice via the protected disclosures policies. However, it had not been identified or reported by anyone in relation to the mis recording of information within car checks, cleaning checks and other documentation.

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

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 provided must ensure that all staff have Children's First training and child safeguarding training and that this is kept up to date.
- The registered provider must ensure that staff have all other required mandatory trainings completed in line with the organisations policies.
- The registered provider must ensure that there is an effective system in place for tracking the completion of mandatory training and that certification of completion is maintained in a central system which can be easily accessed for auditing and oversight purposes.
- The registered provider must ensure that the risk assessment implement in relation to staff members where garda vetting is no longer valid is adhered to.

- The registered provider must ensure that an effective system of oversight and tracking of Garda Vetting is in place to ensure that vetting remains current and up to date as per the organisations policies and procedures.
- The registered provider must ensure that the staff team are trained and can effectively implement the '*Children Missing from Care, A joint Protocol between An Garda Síochána and the Health Service Executive, Children and Family Services'* 2012.
- The registered provider must ensure that all care records relating to this young person are up to date, comprehensive, effective and reflective of the identified risks, vulnerabilities and safeguards in place for this young person.

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 team consisting of two deputy managers and centre manager. The centre manager was also the named Person in Charge for the centre. Staff in interview were not clear on the roles each member of the management team had. The centre manager advised that there was a clear division of tasks in place between the management team however in interview could not articulate what the specific roles were and noted that liaising with the family and social work teams was their own area of responsibility. This division of roles was not clear to the team and inspectors did not observe this reflected within the documents reviewed.

In addition to the roles and responsibilities the centre manager was not aware of some of the systems that were in place within the house to ensure its effective operation. As detailed earlier in this report, the oversight of these systems was not evident or effective as deficits were not identified.

The centre manager was not aware of the specific mandatory trainings required within the organisations policies and that staff were not up to date with these. They were unaware of risks identified within the child safeguarding statement and were not confident in the practice regulations that the centre operated under. Given the

deficits identified within the knowledge of the centre manager during this inspection and the deficits identified within the systems within the centre it was evident that there was a lack of leadership demonstrated within the centre.

During the course of the inspection the centre manager's employment with the organisation was ceased and the deputy manager was appointed in an acting position.

There was a Head of Services in place who had responsibility for oversight of the operations within the centre. Their title had recently been changed to Director of Services however their roles and responsibilities had not changed because of this. There was weekly manager meetings where an overview of the young person and issues arising in the centre was provided to the director of services. They also informed inspectors that they completed audits within the centre monthly and supervised the centre manager. However at the time of inspection only one audit had been completed in the centre in January 2024. While the director of services had identified some deficits to be improved upon through audit, visits to the centre and supervision, they had not completed sufficient follow up to ensure that deficits were addressed and had not identified a number of areas that required improvement including training for staff and vetting.

Staff all had a job description which was held on their supervision file. They spoke positively about working in the centre and the support they received from management. Given the young person had not been present in the centre for a number of weeks and that there was three members of management in the centre five days a week, inspectors could not determine why tasks, such as cleaning or mandatory core trainings remained outstanding. Inspectors did not review any evidence of staff performance or practice being reviewed, or staff being held accountable for tasks remaining incomplete.

At the time of inspection, the named registered provider was uncontactable by the inspection team. The registered provider had sent an email following an inspection in another centre within the organisation, delegating their duties to one of the directors within the company. The management within the centre and staff team advised that the registered provider had not been in contact in a number of months and they were unclear if they were still in this position and were not aware that duties had been delegated. During interview with one of the company directors they advised that they were unclear on the future plan for the registered provider and a meeting was being convened in the coming weeks to clarify this. A plan in relation to this is required to ensure there is clarity in relation to the roles and responsibility of the registered

provider on an ongoing basis as set out in the Child Care (Standards in Children's Residential Centres) Regulations, 1996 and the National Standards for Children's Residential Centres, 2018 (HIQA).

Team meetings were occurring on a fortnightly basis. Within these there was brief discussions of the young person, and other issues arising within the centre. Actions were noted at the end of each meeting and a person responsible for follow up. While this action plan was recorded at the end of the meetings, there was no review of these at the following meeting and as such it was difficult to track actions to completion which resulted in some tasks not being done.

There was a suite of operational policies and procedures in place which guided the practice within the centre. These policies were aligned to relevant legislation and the National Standards for Children's Residential Centres, 2018 (HIQA). The policy document did not specify a date of issue, or a specific time frame for review. Additionally, inspectors noted the policies were in draft editing format. Thus, the final version of this document should be circulated to the centre and staff team.

There was no centre or young person risk register on file at the time of inspection however, there was a number of open risk assessments in place in relation to the young person and the house. Within these risk assessments, the nature of the risk was detailed, the controls in place and they were scored to determine the level of risk. A date of review was included; however, inspectors did not find evidence that these were reviewed in line with the dates indicated. In interview staff and management provided a variety of responses in relation to who was involved in these reviews and there does not appear to be a system in place around this. Additionally, some of the control measures in place were not accurate e.g. risk assessment in relation to arson indicated that staff were fire trained, however not all staff had this training. At times the risk assessments were not accurate or up to date e.g. the risk of missing in care had not been updated despite the young person being missing for an extended period of time.

One risk assessment indicated that restraint should not be utilised with the young person as it was unsafe to do so, however this was contradictory to the individual crisis support plan (ICSP) which indicated that restraint could be used if it was safe to do so. Additionally, not all of the team was trained in the framework for the management of behaviour however there was no risk assessment in relation to this and the impact on the implementation of the ICSP. Improvement in relation to the

identification, categorisation, management and review of risk is required to ensure that risk assessments are effective and up to date.

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

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	**5.2**

Actions required

- The registered provider must ensure that there is an effective management team in place to manage the centre.
- The registered provider must ensure that staff are aware of the responsibility and accountability to meet the requirements of their job description.
- The register provider must ensure that the governance and oversight mechanisms in relation to all areas of operation within the centre are effective and implemented.
- The Director must ensure that there is clarity in relation to the registered provider and who is responsible for the responsibilities as set out in the Child are Regulations and must ensure that the centre management team has clarity in relation to this.
- The registered provider must ensure that the centre has a risk management framework in place and that risk assessments are effective and up to date.
- The registered provider must ensure that the policies and procedures in place include date of inception and the most up to date version is circulated to the centre.

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.

There centre had a team consisting of six full and two part time social care workers, two deputy managers and a centre manager. There was one vacancy currently being recruited for and a further vacancy due in the coming months which was being planned for. The centre had sufficient staff to operate at the time of inspection. In the months prior to inspection the centre had relied on staff from agencies to fulfil the roster however the need for this had reduced in the weeks preceding the inspection and when they were utilised a core member of the team was always on shift with them.

The organisation had a designated recruitment person who was responsible for the recruitment of new workers. Personnel files were maintained in the organisations head office. They included the appropriate references and documentation and staff employed were appropriately qualified. One staff member did not have the appropriate qualification on file and this requires immediate follow up to ensure that they are appropriately qualified for the role they are currently in.

Some members of the team had a number of years' experience and some were newly qualified. As detailed in previous sections staff spoke positively about the environment within the centre and noted that it was a positive place to work at the time of inspection which they reported had not always been the case.

While staff were appropriately qualified, as previously stated some team members did not have mandatory training completed. Supervision was occurring with the team however this was not aligned to the timeframes set out in the policy. Within supervision inspectors noted that while training needs was discussed, there was no focus on the completion of mandatory training and they were not highlighted as significant issues that required follow up.

There was an on-call policy in place for the centre and staff were aware of this and when to use this system. The centre managers and deputy managers within the organisation provided this on-call support. Weekly management meetings reviewed contact with the on-call which facilitated the sharing of information. The use of on-call was also discussed during team meetings. No issues in relation to the on-call system were identified.

Regulation met	**Regulation 6** **Regulation 7**
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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that staff working in the centre are appropriately qualified and have the necessary training.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that records maintained by the centre are accurate and a true reflection of work undertaken.	Centre manager to sign off on all paperwork /records as per task list. Centre manager will complete a record keeping policy review in team meeting on 01.05.24. Designated person visits will be completed once per month to ensure additional oversight for centre records. The audit will be sent back to the centre manager and a CAPA form will be completed and shared with the Director of services.	Director of services will carry out two audits per month. A third audit will take place monthly by a member of management. This audit is called the Designated person audit which will focus on records maintained in the centre.
	The centre manager must ensure that there is oversight from management of records maintained and this is evidenced throughout these records.	Centre manager to sign off on all records. Sign off of records put onto the Centre managers weekly task list. Designated person audits will be completed once per month. This audit oversees records maintained in the centre.	Director of services will carry out two audits per month. A separate audit will take place monthly by a member of the management team. This person is called the Designated person. This audit will focus on records maintained in the centre.

	The centre manager must ensure that the vehicles available for the young person are roadworthy and comply with all legal requirements.	Weekly car check document has been updated to include checking NCT, Insurance and tax. Process put into place for the staff team to notify the centre manager in writing and input onto the handover any issues found in weekly vehicle checklist.	Centre manager will review the weekly car check document after completion. Any issues found with the car will be addressed promptly.
	The centre manager must ensure that the centre is cleaned and maintained to an appropriate standard.	Cleaning schedule in place which is signed off on daily by team members. Going forward physical checks are completed daily by Centre manager. Centre manager to sign off on records when checked.	Director of services completes two audits per month. One of these audits specifically focuses on health and safety, general environment and hygiene.
	The centre manager must ensure that all staff are appropriately trained in fire safety and participate in a fire drill.	Fire safety training completed on 29th February for the staff team. Fire records maintained in the centre are checked weekly by centre manager. Fire safety/fire drill schedule in place on view in office.	Training records are held centrally in the head office. The administrator oversees the training register and reports into the weekly Director of services meeting. The administrator will schedule mandatory training.
	The centre manager must ensure that the fire doors are effective and in working order.	Work has been carried out on fire doors. Engineer called to the centre on 01.02.24 and certified all doors. The team have been	Centre manager oversees records maintained in the centre and reviews fire safety documents, and maintenance

		made aware to report issues with fire doors immediately to centre manager. Fire doors checked daily by the team. Maintenance checks completed each Wednesday.	records. All issues escalated to the Director of services.
	The centre manager must ensure that there are clear records of maintenance requests inclusive of timeframes.	On 1st February a new weekly maintenance request form was created. This is completed by the centre manager each Wednesday. All records are sent to the Director of services who sends the maintenance list to company's maintenance person.	Maintenance request form is printed and kept in the maintenance folder in office. Maintenance person signs off on work completed. The maintenance is overseen by centre manager and director of services.
	The registered provider must ensure that the centre manager and team are aware of the procedures for recording and reporting accidents within the centre.	Review policy for reporting accidents and complete at team meeting on 18.04.2024 Accident folder in place, with accident report forms available. Copy of the policy and procedure for reporting accidents printed and put into folder.	Policy and procedures training will be scheduled for the team to complete. The training will include the procedures for reporting and recording accidents within the centre.
3	The registered provided must ensure that all staff have Children's First training and child safeguarding training and that this is kept up to date.	Training tracker reviewed by centre manager. Child Safeguarding training took place for the team on February 29.02.24. This	Mandatory training in children's first, mandated person training will be completed in induction phase. All team members will complete appropriate child

		training covered all important areas on Child protection for SCWs working in Childrens residential services. All team members have Childrens first training. And other mandatory training.	safeguarding training
	The registered provider must ensure that staff have all other required mandatory trainings completed in line with the organisations policies.	Training tracker implemented on 18.01.2024. This tracker has all team members, and dates for all trainings completed and dates due for renewal. Team members have completed Fire safety 08.02.24, Manual handling 08.02.24, Medication training 29.02.24.	Tracker overseen by administrator, who attends weekly Director of Services meeting and provides an update/overview on training at the meeting. Process put into place for mandatory trainings.
	The registered provider must ensure that there is an effective system in place for tracking the completion of mandatory training and that certification of completion is maintained in a central system which can be easily accessed for auditing and oversight purposes.	All training certificates have been centralised to the head office. This is overseen by administrator. Training certificates are stored in the staff files, and a digital copy is stored on a sharing software. The date of renewal is located on tracker on the sharing software.	An update on training records is provided weekly at the Director of service meeting by the administrator who oversees the training records. The tracker is on the weekly tasks list of Social care manager

	The registered provider must ensure that the risk assessment implement in relation to staff members where garda vetting is no longer valid is adhered to.	Team members whose Garda vetting is coming towards renewal will be notified well in advance. The centre manager is notified by email by administrator, along with the team member. Should a situation occur where the Garda vetting is due to expire and application not received back, the centre manager will be notified and will implement a risk assessment for the team member. The risk assessment will be shared with the team member and will be available in the house records.	The administrator reports into the director of services weekly meeting to provide an update on Garda vetting. The director of services checks the Garda vetting tracker weekly to ensure that there are no deficits and to ensure that appropriate risk assessments are in place where garda vetting is close to expiry, or no longer valid.
	The registered provider must ensure that an effective system of oversight and tracking of Garda Vetting is in place to ensure that vetting remains current and up to date as per the organisations policies and procedures.	Garda vetting process reviewed at DOS meeting on 07.02.2024. Garda vetting tracker implemented and overseen by Administrator in head office. Team members will be notified 2 months in advance of expiry date to renew. All situations where Garda vetting is coming close to being out of date, needs to be shared with the DOS, relevant to the staff member and centre manager so that risk assessment can be put into place if	Garda vetting update provided weekly at director of services meeting by administrator. Tracker available on the sharing software and checked by Director of services weekly.

		required.	
	The registered provider must ensure that the staff team are trained and can effectively implement the '*Children Missing from Care, A joint Protocol between An Garda Síochána and the Health Service Executive, Children and Family Services'* 2012.'	Copy of 'Children Missing from Care, A joint Protocol between An Garda Síochána and the Health Service Executive, Children and Family Services' 2012 printed and left in house 22.01.24, copy shared with the social care team. Training scheduled on the company's policy and procedures for missing child in care and the joint protocol on 29.03.24	Going forward this will be included in policy and procedure scheduled training. A review of the joint protocol will be an agenda item on house team meeting on 30.04.2024 to review. A copy of the document and policy will be available in the centre read and signed by the team.
	The registered provider must ensure that all care records relating to this young person are up to date, comprehensive, effective and reflective of the identified risks, vulnerabilities and safeguards in place for this young person.	A daily social care worker task list has been put into place with a breakdown of records and tasks that need to be completed. The centre manager reviews all records weekly, as per task list. Significant event review meeting takes place weekly, attended by all the management team and team members available. Centre manager is responsible for overseeing all records within the centre taking into account identified risks, vulnerabilities and safeguards needed.	All care records relating to young person are overseen by the centre manager and Director of services. There are 2 audits carried out by the director of service monthly to ensure that all records are up to date, comprehensive and effective.

5	The registered provider must ensure that there is an effective management team in place to manage the centre.	Recruitment will ensure that the centre managers qualifications & experience are in line with Alternative Care Inspection & Monitoring Service Regulatory notice - Minimal Staffing Level & Qualifications for Childrens Residential Centres. Centre manager receives appropriate supervision from Director of services fortnightly.	A full-time recruitment person is in place and there is an active recruitment drive at all times for management positions. Where there is a delay in employment, an acting manager will fill the position who is appropriately qualified and experienced. Managers receive fortnightly supervision by the Director of services, and the first 6 months of employment a probation review is in place.
	The registered provider must ensure that staff are aware of the responsibility and accountability to meet the requirements of their job description.	Job descriptions will be reviewed individually with team members and members of management during supervision throughout the month of April. Workshop on the responsibility and accountability to be designed by the Director of services, and scheduled to compete with the team and management on 17.04.2024	Job descriptions sent to the employee upon commencement of employment. Job description to be reviewed with each employee during supervision.
	The register provider must ensure that the governance and oversight mechanisms in relation to all areas of	The director of services attends a weekly briefing meeting with the management team. Monthly management meetings	Governance and overnight meetings occur weekly and attended by the Director of services, accounts, recruitment and

	operation within the centre are effective and implemented.	occur with the Director of services and management team to complete an in depth governance and oversight meeting	Director. In January 2024, the governance and oversight auditing structures were reviewed, and an auditing schedule has been put into place to ensure oversight and compliance. Director of services will complete two audits in the centre per month. The designated person completes 1 audit per month.
	The Director must ensure that there is clarity in relation to the registered provider and who is responsible for the responsibilities as set out in the Child Care Regulations and must ensure that the centre management team has clarity in relation to this.	The Director has been nominated as main contact for registered provider in the interim. This information was notifiable to inspectors, director of services and centre management.	Going forward any update of change in regard to the registered provider will be communicated immediately with the centre manager in writing, by the Director of services.
	The registered provider must ensure that the centre has a risk management framework in place and that risk assessments are effective and up to date.	Full review of risk assessment register had been completed by centre management. Risk assessments are on the centre managers weekly task list for review. All medium to high risks are notified to the Director of services immediately for review.	Risk management discussed weekly at the director of services meeting. Risk management discussed monthly with all managers during monthly management meeting. Risk management is an agenda item on all centre manager supervisions.

	The registered provider must ensure that the policies and procedures in place include date of inception and the most up to date version is circulated to the centre.	The current and most up to date policies and procedures are saved on the sharing software accessible to all employees. A soft copy is kept printed in the house. Where there is a change to policy and procedure documents circulation is sent to all employees and the centre manager receives a copy to keep in the house.	Any change in policy and procedures will be shared with the employees, an electronic copy will be circulated and a physical copy will be stored in the centre.
6	The registered provider must ensure that staff working in the centre are appropriately qualified and have the necessary training.	Recruitment will ensure that the centre managers qualifications & experience are in line with Alternative Care Inspection & Monitoring Service Regulatory notice - Minimal Staffing Level & Qualifications for Childrens Residential Centres. Records for all employees qualifications are kept in their staff file in head office, and also saved on the sharing software.	Induction process includes a number of mandatory trainings to be completed before starting. Training reviewed and updates provided at weekly director of services senior management meeting.