An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 202

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Ideal Care Services Ltd**
Registered Capacity:	**One young person**
Type of Inspection:	**New centre first inspection**
Date of inspection:	**17th & 18th August 2022**
Registration Status:	**Registered with conditions attached from the 11th of March 2022 to the 11th of March 2025**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**15th December 2022**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 31st of May 2022. 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 the 31st of May 2022 to the 31st of May 2025

The centre was registered to provide single occupancy for a young person aged between thirteen to seventeen on a short to medium term basis. The centre had been created with the aim to accommodate young people with complex behaviours that had led to placement breakdowns and disruption to their lives. Their model was to take a strength based and non-confrontational approach to young people in a safe, consistent and tolerant 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	2.2
3: Safe Care and Support	3.2
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 worker 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 on the 21st of September 2022 and to the relevant social work department on the 21st of September 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 5th of October 2022. This was deemed to be not satisfactory and the inspection service did not receive adequate evidence of the issues addressed. There was additional CAPA follow up on the 13th of October, the 27th of October and the 3rd of November 2022.

The findings of this report and assessment of the submitted CAPA deem the centre to be not continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 202 with attached conditions from the 31st of May 2022 to the 31st of May 2025 pursuant to Part VIII, 1991 Child Care Act. The condition being:

- There shall be no further admissions of a young person to this centre until such time the centre has fully implemented the corrective and preventative action plan and is compliant with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III Article 5: *Care Practices and Operational Policies,* so that appropriate suitable care practices and operational policies are in place, having regard to the number of children residing in the centre and the nature of their needs. The condition will be reviewed on or before 28th February 2023.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

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

At the time of the onsite inspection there was no up to date statutory care plan on file and nor had a statutory review been held which was two and a half months into placement. A copy of any previous care plans was not on file either. Inspectors were informed by the social work department, the centre and the Guardian Ad Litem that repeated attempts to schedule this had encountered a variety of delays. A date had been secured and confirmed for two weeks after the inspection. Inspectors found that the team were not fully aware as yet regarding the different types of plans and their statutory footing inclusive of time frames. There was evidence of some overlapping in language between references to a care plan and a placement plan and a lack of urgency in requesting the most recent care plan or to escalate action on the absence of a care plan for the placement. Inspectors found that due to an existing approach to recording that it was not possible to track the centre's efforts to seek a care plan nor were there detailed records of any meetings agreeing the goals, the placement type or its purpose on file between the social work department and the centre.

The key worker and the director had created a placement plan for the young person, the goals within this were limited in scope and in the main cross referenced to plans for the management of behaviours that challenged. Inspectors found that the focus was mainly on day to day containment and activities for the young person and that crucial aspects of care remained unclear. Inspectors found this to be due in part to a lack of a care plan and a lack of structured regular planning meetings such as professional's meetings or strategy meetings. There was also a need for better policies and enhanced implementation of their roles and tasks by the team. Inspectors found that the centre management must request regular formal meetings with the social work department and other professionals to clarify and advise their service provision for any young people in their care given their stated purpose and function. The management team must also support team development into a fuller

implementation of their training, skills and abilities within a registered children's centre setting.

The placement plan had been developed utilising a model that a small number of staff had trained in previously and it was not a model currently invested in by the company. The full range of tools underpinning the scoring approach of this model were not evident on file. The resulting placement plan required attention regarding identification of goals, naming the work needed to achieve those goals and the resourcing of the means to achieve these with the young person. There was no effective review system established as yet to track the meeting of key work objectives. There had been team meetings established on a fortnightly basis and the minutes evidenced discussion of the placement plan. The team requested that the social work department source suitable clinical and therapeutic supports. Whilst it was appropriate to look to the social work department for many clinical aspects the team can take a more active role through training, key working and linking to local community based services for example. Inspectors found that the social care leader had started researching and connecting with local community based support services with the aim of exploring suitable non clinical services.

As inspectors conducted further review through interview it revealed positive achievements and work completed in supporting the young person's existing education and for a return to school that was also largely undocumented on file. It is essential that the standard of the filing system and the approach to recording become more comprehensive. More evidence around the work being attempted was contained within the daily and weekly reports but these also fell short of what the teams stated and requested work were to be from the pre-admission risk assessment plans. These records and reports would benefit from restructuring in line with the systems and requirements of a residential placement, for example to include sections for significant incidents, key work, risk management, placement planning and to highlight the lack of a care plan for example.

There was evidence of a tool used to engage the young person in consultation about their placement and the plan and the professionals noted that the young person and their key worker communicated well.

A young person spoke with inspectors but said little about their experience aside from being happy with their room and overall with the placement. Their guardian ad litem and the social work department named that there had been stabilisation at this centre which had provided the professionals an opportunity to plan but that it was

clear that the centre had significant stages of development to go through. All the professionals and the family, as well as the young person were satisfied for them to remain there whilst the long term plan was confirmed.

There were no copies of previous clinical assessments provided for the file although some records referred to two diagnoses. The centre had been advised that one of the two referenced had been clinically verified but that investigation was ongoing regarding that and the second named disability. The GAL had requested the social work department to source all historical information to allow for a full updated assessment to take place. Inspectors did not see evidence of the centre seeking clarification on the diagnosis nor of advocating for access to the previously involved CAMHS service. There was little information on the file on how to respond to the presentations related to a specific named disability. Although there was some evidence provided of communications with the social work department regarding specialist services these did not raise requests for the need for more information on how to approach caring in the now.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 2.2**

Actions required

- The centre management team must ensure that all staff are aware of the differentiation between the statutory planning, the role of care plans and the placement plan for children in residential care
- The centre management team must ensure that they introduce a set of escalation measures for statutory care plans where not provided by a social work department.

- The centre management team must create a suitable reporting and recording file system for young people's placements. Core documents such as copies of care orders must be requested for the file.
- The centre management team must agree on a placement plan format and support the implementation of that placement plan format inclusive of the dedicated training if that is required by the model chosen.
- The staff and management must expand their approach to planning and agreeing goals and in recording the key working and individual work sessions identified with it.
- The registered provider and centre management must ensure that service provision is provided in accordance with the stated purpose and function.
- The registered proprietor and senior management must implement detailed measures to ensure team development in support of the centres purpose and function.

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

The centre's policies and procedures identified the centre as a placement type on a short term basis for complex young people with service resistant and challenging histories. There was no current policy dedicated to positive behaviour support but one aspect of the aims and model section did contain a focus on taking a strengths based and non reactive approach to challenging behaviour with the aim of restoring the routine as soon as possible. Inspectors found evidence of elements of this approach recorded in the daily records. Inspectors found that the team had been introduced to the available policies during the opening of the centre and were aware of aspects of the core model.

The policy areas containing the aims of the model of care were multi-layered and ambitious and required significant work to become more cohesive and a workable guide to the daily intended work of the whole team in what they aimed to achieve, and how, with a young person given the purpose and function. The team will require training on the model and on the policies and procedures including the National Standards for Children's Residential Centres 2018 HIQA, through a development

plan. The team had not received access to specialist support and advice regarding the specific nature of the model nor for the current placement to date. The director of services informed inspectors that a review of the model of care was being completed and would be shared with staff once completed.

The majority of the staff team were trained in one model of managing behaviours that challenge whilst the policy on same and the tools in use on file were based around a different model of management of behaviour. Inspectors require that this be corrected without delay and the team and the recording system aligned to one cohesive approach and model. Those staff requiring training must have this scheduled.

During review of documents and interviews conducted inspectors found that the staff took a non-confrontational approach and aimed to provide a daily and weekly activity structure. Some elements of this had proven suitable but inspectors found an absence of evidence of other routine daily activities such as meal times and cooking. Again, when this was raised the centre stated that there was daily cooking and shopping that on occasion involved a young person when they wished to do so. There was evidence of a poor dietary intake and a structured plan must be evidenced on file to account for the efforts made by the team to address this.

The records on file contained the use of plans for the management of crisis behaviours based on the plan created by a previous service and shared with the organisation. The centre then added some additional aspects noted during their care provision through review of the plan. The centre had completed their own admission risk assessment and had been provided with a copy of a Tusla created pre admission risk assessment. These documents inclusive of their requirements and recommendations did not correlate directly to the plans in place at the centre. Aside from the individual crisis management plan and the individual absence management plan significant important information had not been prioritised for bringing into the team's awareness and day to day work. In particular information related to incidents of a child protection nature and their possible risk implications were not defined.

The staff team evidenced knowledge of the advice contained within the individual crisis management plan/ICMP but mainly relied on a model of high tolerance of negative or targeting behaviours in favour of letting the incident run through and then approaching a young person to engage. There was also evidence of the use of the Gardaí on occasion when a young person was unresponsive to staff direction when outside the centre. Under this type of approach there was under reporting of

significant incidents and an acceptance of the impact on staff. This approach also created a gap in potentially important information for clinical review and for onward specialist referral for placements. The staff team must be supported to enhance their approach to behaviours that challenge through consistent and good quality reporting. There must also be review of incidents that look to bench mark staff actions against the behaviour management plans and the policies in place. The reviews must thereafter inform adaptations in responses in a manner that ties together the model, the policies, and the individual needs of a young person at a time of crisis. And there must be a streamlining of the type and title of plans the centre may decide to utilise as part of their service provision.

The staff team did have access to plans designed to address behaviours that had been reviewed and updated and they demonstrated a respectful and professional approach to caring for young people. They also had co-ordinated with a young person, the social work department, the GAL and family to put in place a regularly reviewed agreed absence management plan. There had been discrepancies recorded on an incident report that displayed deviation from the agreed absence plan and inspectors identified same for immediate review and action by the centre. The social care leader responded to this and stated that it would be completed with all staff. The centre must establish a means by which they can reliably track concerns and raise these for consideration as part of the planning for young people.

Another commitment made in the model of care was the teaching of self-regulation, self-insight and skills development for young people and about being realistic about what can be achieved as an outcome in a short time frame. Due to the low volume of recording completed it was not possible to see how or if that had been achieved but family and professionals noted some aspects had improved particularly around communication but that the role of the full staff group in influencing positive outcomes remained unclear to them.

Inspectors found a record of a staff placing their hand on a young person in a non routine physical intervention but did not find that this had been discussed for learning or identified as accurately in line with the existing model of physical intervention some of the staff had trained in. It is essential that actions such as this be reviewed to ensure compliance with policy and safety for a young person and staff. This should be a routine part of the role of a person in charge.

The centre management and the director had established the need to do internal oversight and audit, there was no system developed for internal oversight and audit

as yet. The staff meetings and supervision had commenced and these contained aspects of internal oversight or the potential for same. Daily handovers took place inspectors were informed but the style of recording these did not identify what areas may have been discussed regarding direction, accountability and review of approach. The team did not have a recorded and recognised system established for restrictive practices and there was low awareness of its role in the team works. The restrictive practice team knowledge, the procedure, the recording and system for reviewing thereafter must be developed and implemented at the centre.

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

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

Actions required

- The registered proprietor and director must ensure that the team have access to information and guidance on the model of care inclusive of the model of positive behaviour support.
- The centre management must ensure that an accurate profile of a young person's challenging incidents are recorded and reported.
- The centre management must ensure that incidents are formally reviewed for practice, learning and adapting responses where required.
- The policy on management of behaviour must be consistent and congruent with the chosen training method of management of crisis behaviours.
- The registered proprietor and director must audit training and identify any outstanding staff who may require the training in the method of management of crisis behaviours.
- The director and centre management must introduce a procedure and means of identifying, recording and reviewing restrictive practices.

- The social work department must ensure that the young persons clinical and therapeutic needs are prioritised for action.

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.

Inspectors were informed that due to unforeseen circumstances the named person in charge, the social care manager, had not been present in the centre for significant periods of time since its opening at the end of May 2022. The social care leader who joined the team shortly after the opening of the centre acted in lieu of the centre manager but was not the named acting manager. The inspectors received positive feedback on the role undertaken by the social care leader in the centre managers absence, they were named as providing daily organisation, good communication and leadership.

A young person and various professionals did not know the named centre manager but were familiar with the director and the social care leader. The senior management team must create a formal delegation record and account for the acting up arrangements in a structured manner. There must be clarity in the tasks that were and are allocated in this acting up arrangement. This must be thereafter tracked and supported through robust external governance that must be evidenced. Inspectors saw that the rosters placed the social care leader on week days but the rosters that were provided for inspectors did not record when the centre manager was present nor in fact which personnel filled the roster on all days. Later copies were to be provided for inspection review that the management stated displayed all the names of staff on duty.

There was little evidence recorded of the oversight of records aside from by the social care leader who appeared to have completed significant sections of the planning in conjunction with the director. The director was visiting the centre regularly including on an unannounced basis but there was no evidence recorded of their work or observations regarding the operation of the centre whilst present there. The senior management team and the registered proprietors must ensure that there is clarity

regarding who is the centre manager or acting in that capacity. Inspectors found that audit and compliance actions were required for staff personnel files and for the training records of staff. The person in charge day to day must have clear information about and knowledge of relevant legislation, regulations and the national standards. They must have access to and knowledge of up to date and accurate policies and procedures that they in turn can lead their team in bringing into practice. Inspectors established that there were significant areas for development and current gaps in these areas and in the team's available tools and procedures for practice.

The director had established management meetings and had begun to create a structure for service development and must now create a timeline for all the urgent areas for development so as to embed good governance and clear leadership at the earliest point in the centre's development. The staff team as a group had commenced supervision and evidenced a strong positive focus on their development and training. The management must develop training and development plans that reflect these goals, the director named that dates were being developed for the rest of the year and beyond for staff training.

The centre had a set of policies and procedures developed for the centre, areas for development and implementation have already been named in the report related to behaviour management, placement planning and restrictive practices. The team must have a reviewed cohesive set of policies and procedures. There were a range of policies some in one document and others standalone, these must be combined, and the team provided with internal training in the relevant core areas for daily practice as a priority and in a structured plan thereafter for the full range. The correct references must be used on the policies as some provided referred to draft national standards that predated the current National Standards for Children's Residential Centres 2018 HIQA.

There must also be attention to the creation of filing systems and recording and reviewing practices to support the expansion of the role of the team and creating a record of their work. The files must also when expanded contain a copy of a young person's care order, any consents or agreements, there must be a confidential section where one may be required and good quality records of contacts with social workers and other professionals. The staff team must complete training in the role of mandated persons and the policy on child protection reviewed by all as part of their internal training. The staff team must be registered on and aware of how to make a report through the dedicated Tusla portal for child protection reporting. There was evidence that this was not the case across the team.

There must then be evidenced internal governance of the recording, reporting and filing system to ensure that the whole team become involved. There must also be

registers established including an admissions and discharges register and a significant event reporting register. There was a record established for tracking complaints which to date related only to the social work department and were not reported, as standard, as a significant event. The social work personnel involved were aware of these and had met the young person to seek to resolve them locally. The GAL was also aware of the matters arising.

Inspectors found that the team had an understanding of risk and that there were individual components such as risk assessments established on record. These had not been co-ordinated into a shared understanding across the team of what a risk management framework for this centre would look like. Any action related to risk assessment and management whether related to young people or for example for the site-specific risk assessments had been completed by the director or the social care leader. A centre risk management framework will need to be expanded upon and existing matrices for measuring risk implemented in the records, if that is to be the intended approach, in support of the centres development.

The organisations approach to internal oversight and to external monitoring and governance must be implemented in support of the centres ongoing development.

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

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

Actions required

- The registered proprietor and the director must create a formal delegation record and account for the acting up arrangements in a structured manner.
- The registered proprietor must resource and develop a full set of policies and procedures that comply with the national standards, legislation, national policy and the purpose and function of the centre.

- The registered proprietor and the director must implement a staff training programme for the updated policies and to enhance knowledge of the National Standards for Children's residential centres 2018 (HIQA) for the centre team.
- The centre management must implement recorded internal oversight and governance of the systems at the centre in their day to day work.
- The director and registered proprietor must commence their external recorded governance and oversight approach to add to the existing meetings and records in place.
- The director and centre management must expand the risk management framework supported by policy, tools and records to further support staff development in the identification, assessment and management of risk.
- The director and centre management must ensure that the items identified for action from the personnel files are completed and the personnel files updated. The centre management team must ensure that they audit staff personnel files and staff training records on a regular basis.

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.

Inspectors found that the team consisted of a centre manager plus nine identified social care staff, one of whom was a social care leader. In effect the staffing was a social care leader covering for the centre manager plus eight. This still allowed the centre to be in compliance with the ACIMS staffing and qualifications memo updated April 2022 and circulated to all providers. The staff team were over fifty percent qualified in social care and provided daily double cover for sleepovers with the third person present being the social care leader typically Monday to Friday.

There was evidence that work force planning occurred through a number of mechanisms, the core two being the creation of rosters and through the ongoing recruitment of staff to the company. The rosters provided to inspectors had blank spaces and therefore could not be matched fully with the current staff list. The names on daily records at the centre did correlate to the majority of the named core team.

The rosters must record accurately who was in the centre as should daily logs, handovers, sign in sheets and so forth in order to maintain fire safety, safeguarding, accountability and all aspects of centre consistency in care delivery. The staff team as a whole did not contribute widely to the records due to the current structure of the files but did maintain good daily records. It was possible to identify that sufficient numbers of staff were present and that attention had been paid to ensuring some specific staff were available for the types of physical activities preferred by a young person. The nature of the records did not highlight the competencies across the team and inspectors acknowledge that while this was an early stage in the centres development the roles for all staff must become clearer and more proactive. The interviews conducted with staff revealed motivated members of the core team.

Inspectors reviewed interview notes maintained on four recent personnel files and found that records named two interviewers and that one of them was the centre manager alongside the director. There had been some recruitment through social and professional contacts and the management stated that recruitment and selection criteria were always applied thereafter, and the sample of records supported this. There was no list of relief staff provided but regular names appeared on the rosters and the director stated that a list of named relief will be provided for the record. Two staff named that they worked in accordance with their contracts of employment and were positive about the centre. There was some limited feedback from a young person who mainly identified with their key worker and a few staff that they completed activities with. The professionals and family stated that in general team communications had improved through their contact with the social care leader.

The director was the sole provider of on call cover for evenings and weekends with some involvement for the social care leader who was the other senior person to receive significant event reports. The director's number was displayed on the staff office along with a short procedure for same.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**None identified**

Actions required

- The centre management must ensure that the rosters are updated to contain the names of those who completed the shifts. The names of the identified current relief staff must be verified.
- The staff must ensure that they record the names of all on duty at handovers and in daily planning to ensure fire safety and daily accountability.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre management team must ensure that all staff are aware of the differentiation between the statutory planning, the role of care plans and the placement plan for children in residential care.	A statutory care plan was provided by the SW department on the 22nd of September. Management engaged an experienced external consultant who conducted a review of the care plans and staff understanding of their role. This review was carried out on the 24th of Sept. The result finds that care staff are aware of the differentiation between the statutory care plan and the placement plan but the advising professional recommended that a refresher course was needed to update staff at the centre on all statutory requirement for child placed in residential care. A refresher training course has been scheduled for the 15th of October, 2022. Staff shall be trained and assessed for their understanding of the pre-placement assessment process, statutory care plan, placement plan, social histories, IAMP,	Key working and other statutory pre-requisites in order to provide safe and effective care and support for the child are discussed at scheduled care staff team meetings. This shall be reviewed every two months. This understanding of statutory documentation shall be included as a KPI in the monthly supervision meetings and during 1:1 meetings with the centre manager.

		safety plan, risk assessments etc.	
	The centre management team must ensure that they introduce a set of escalation measures for statutory care plans where not provided by a social work department.	During the staff meeting held on the 24th of Sept director of operations established a policy of escalatory protocol for engaging with the social work department where statutory documentation (including care plans) are not provided on time.	The stipulated escalatory protocol shall be followed by the centre manager and monitored by the director of operations. Action: centre manager and director of operations. A record of correspondence with social work teams will be kept within each young person's care record as the correspondence occurs.
	The centre management team must create a suitable reporting and recording file system for young people's placements.	These measures include a) comprehensive checklist of all required info and documentation in the young persons personal file. b) Ensuring that all file is complete 48 hours after commencement of placement. Where any required documentation is still outstanding, the Centre Manager should ensure that the required department/professional is contacted to provide this document. d) Whereby there is no response from the responsible professional, within 24 hours, a follow up communication (preferably by email) shall be made reminding of same.	A new communication log shall be used to log, track and monitor all communication noting time of original communication and response time from the SW department.

		e) If the responsible professional still fails to provide the documentation after another 48hrs, the professional's line manager shall be contacted. This sequence of escalatory contact shall be maintained until the required statutory document is provided. Action is by the centre manager. All communication shall be logged in the communication log with details of time of contact, mode of contact and timing of response. A statutory care plan was provided by the SW department on the 22nd of September.	
	The centre management team must agree on a placement plan format and support the implementation of that placement plan format inclusive of the dedicated training if that is required by the model chosen.	The centres model of care is to take a strength based, non-confrontational approach to young people in a safe, tolerant and consistent environment but the placement plan was underpinned by the principles of Welltree model of care. The director of operations announced a full transition to Welltree Model of care and a creation of a wellbeing outcome framework to commence in October 2022.	The young person's placement plan shall be updated as required on an ongoing basis and a full review every three months by the centre manager and key worker. The placement plan shall be shared with the allocated social worker and clinical support team.

		This model of care encompasses a range of theories and approaches under trauma, attachment, risk and wellbeing. The director of operations has committed to engaging Welltree and to fully provide resources for this transition by engaging the consultant who devised the model for training staff. A confirmation date for commencement of training is yet to be confirmed.	
	The staff and management must expand their approach to planning and agreeing goals and in recording the key working and individual work sessions identified with it.	A review of the key working process was done at the management meeting of 24th Sept, 2022. Clear objectives for key working have been agreed upon. The working process shall ensure that clear goals are agreed and a strategy for achieving these goals are articulated. Centre staff shall use the individual work sessions as a key tool for listening to the young person and taking in their input regarding their care. It shall also be used to assess the progress towards goals and an effective mechanism for addressing	A co-key worker has been appointed. To close the gap on opportunities for key working. Management is committed to providing full training on the advice of clinical professional.

		follow up issues from previous interventions. New approach to planning and recording key working shall be aligned with the new approach in our model of care. Key components shall include measurement of outcome by key worker and the young person.	
	The registered provider and centre management must ensure that service provision is provided in accordance with the stated purpose and function.	The aim of the service provided by the centre is to offer effective help to young people who have a history of numerous unsuccessful placements such as family care, foster care and mainstream residential care. Our service is specifically towards young people with troubled and traumatic histories who have acquired a reputation for challenging and service resistant behaviour. To do this, we shall be transitioning from a strength based, non-confrontational model of care to the Welltree model of care. Management have arranged for a refresher training in the principles of our stated	A quarterly auditing schedule has been developed and the advising clinician will visit the centre to review care practices and operational policies and ensure the centre is compliant with its stated purpose and function. The director of operations will carry out auditing of the centre as required. These findings will be discussed at the monthly governance meeting with the centre managers.

		purpose and function. This shall be done by the director of operations and clinical adviser. All staff would have been re-inducted by the 15th of October, 2022. The tenets of the centre's stated purpose and function with our chosen model of care shall be reflected across all of the documentation including the daily logs, key working, individual work and placement planning and review.	
	The registered proprietor and senior management must implement detailed measures to ensure team development in support of the centres purpose and function.	In addition to the suite of training during the period of transition to the Welltree model, management is working in conjunction with a clinical adviser to identify and deliver targeted training schedule with a structure aimed at providing training to staff to support the centre's purpose and function. Training commences on the 15th of October.	A training schedule has been developed The centre manager and the director of operations will carry out auditing of the centre as required. The audit shall include monitoring staff development and effectiveness of training through feedback from staff and measurable outcomes.
3	The registered proprietor and director must ensure that the team have access to information and guidance on the	Consequent to feedback from this inspection, clinical support is being provided by experienced consultant to	A forum for feedback shall be provided at regular staff meetings and during supervision to identify specific areas of

	model of care inclusive of the model of positive behaviour support.	address effectiveness of our practice with our chosen model of care which is strength based, non-confrontational approach. This support shall continue through until the transition to the Welltree model is complete and all staff including nominated relief staff are fully trained up.	support each member of staff needs. Centre management shall ensure that a robust plan for staff training and development is put in place and resources for staff training are prioritised.
	The centre management must ensure that an accurate profile of a young person's challenging incidents are recorded and reported.	A review of incident reporting format and practice was carried out. A clear approach of a detailed recording of challenging incidents and concerning behaviour will be promoted. Details of events will be factual and cover all stages of from pre-crisis to crisis and back to baseline. All incidents are reported and logged and this shall inform the updating of the placement plan if required. All significant events are indexed, and a clear reporting protocol is informed to all staff.	Centre management shall take a proactive role in ensuring the quality of reporting of all challenging incidents. Centre register shall be updated daily and staff sign off on handovers that have clear briefing of previous challenging records.
	The centre management must ensure that incidents are formally reviewed for practice, learning and adapting	All recorded incidents shall be reviewed at staff meetings with a view to reflect and learn from any variations of presenting behaviours. These reflections shall inform	The weekly report sent to the SW department and to management shall include a section of register of challenging behaviours. This shall be done by the

	responses where required. The policy on management of behaviour must be consistent and congruent with the chosen method of management of crisis behaviours. The registered proprietor and director must audit training and identify any outstanding staff who may require the training in the method of management of crisis behaviours.	any alterations in interventions being employed and updating the placement plan where necessary. Management of behaviour in the centre shall transition from the ICMP approach of triggers and mitigating strategies and fully adopt the 'Positive Behavioural Support' approach. This approach shall be used to support behaviour change in the young person. The focus shall be based upon the principle that if you can teach someone a more effective and more acceptable behaviour than the challenging one, the challenging behaviour will reduce. As a result of the draft findings of the inspection, all staff have been nominated for training with the newly engaged clinical team commencing on the 15th of October, 2022. A robust training schedule is being developed to ensure a sustained development of the centres core team in delivering effective care.	acting centre manager. The behaviour support plan shall be reviewed and updated regularly as informed by learnings from the young person's previous incidents. This review shall be conducted by the deputy centre manager with oversight from the director of operations. The director of operations shall maintain a database and of centre staff and a schedule of all required training undergone. A monthly review of this record shall be done to identify any staff who may have any gaps in training.

		This support shall continue through until the transition to the Welltree model is complete and all staff including nominated relief staff are fully trained up.	
	The director and centre management must introduce a procedure and means of identifying, recording and reviewing restrictive practices.	Though the centre aims to promote a care environment that is free from restrictive practices, the centre manager and director of operations held a meeting on the 28th of September to introduce a procedure for identifying, recording and reviewing restrictive practices.	Restrictive practises shall be monitored by the centre manager to ensure compliance with evidence-based practice. Clinical adviser shall advice on person centred measures that are effective and goal oriented.
	The social work department must ensure that the young person's clinical and therapeutic needs are prioritised for action.	Acting centre manager held a meeting with the newly allocated SW and the SW Team leader on the 29th of September, 2022. Outstanding clinical needs and referrals for the young person were discussed and clear actions were agreed. Review of outcomes is scheduled for 7th of Sept, 2022.	A communication log shall be maintained to monitor all communication with SW department and to identify any actions or interventions that need to be prioritised.
5	The registered proprietor and the director must create a formal delegation record and account for the acting up arrangements in a structured manner.	On the 28th of September, centre social care leader was formally promoted to centre acting manager. A formal list of duties and responsibilities for the role was	Director of operations shall be proactive in identifying and ensuring management oversight in the centre.

		issued for the acting capacity.	
	The registered proprietor must resource and develop a full set of policies and procedures that comply with the national standards, legislation, national policy and the purpose and function of the centre.	Director of operations has engaged the services of expert consultant to review and update as required the full set of policies and procedures so as to comply with national standards. This review is aimed at aligning our approach and service provision with the stated statement of purpose and function of centre. This shall be completed by the 17th of October 2022.	A quarterly auditing schedule has been developed the centre manager and the director of operations will carry out auditing of the centre as required.
	The registered proprietor and the director must implement a staff training programme for the updated policies and to enhance knowledge of the National Standards for Children's residential centres 2018 (HIQA) for the centre team.	A staff training programme was drawn up. the centre manager will ensure that all training for the updated policies shall be delivered to all staff including nominated relief staff	The director of operations will carry out a review of the training and ensure a process is followed where training and staff performance review are active and training needs/areas of development are identified.
	The centre management must implement recorded internal oversight and governance of the systems at the	The centre manager (acting manager) will be responsible for taking the necessary actions identified in this CAPA to oversee	Centre management will ensure audits are completed monthly relating to the CAPA and any gaps will have an action plan

	centre in their day to day work.	the delivery of robust arrangements and structures relating to the day-to-day provision of care to the young person. This is effective immediately.	completed with strong oversight and follow up completed. In addition, areas relating to the CAPA will be discussed at management meetings with the registered providers. Any identified issue will be actioned and followed up on.
	The director and registered proprietor must commence their external recorded governance and oversight approach to add to the existing meetings and records in place.	A record of each centre visit will be completed. In addition, a monthly audit on the CAPA will be completed each month to reflect the oversight and governance to illustrate the physical presence of senior management in the centre to oversee the realisation of actions plans identified in response to inspection findings.	Director and registered provider shall ensure that an unwavering commitment is made for the providing strong oversight of the centre and recording of same.
	The director and centre management must expand the risk management framework supported by policy, tools and records to further support staff development in the identification, assessment and management of risk.	The centre manager for this centre is responsible effective immediately for the identification, assessment and robust management of risk. The centre manager will liaise with the director of operations and social work department effective immediately. Centre and Organisational registers will be developed and be in effect by 17th of October, 2022 following the full	Centre manager will ensure that the identified corrective actions are implemented by the timeframe noted. In addition, the director of operations will ensure risk assessments and risk management practices are reviewed during centre visits and monthly audits in the centre in addition to them being discussed at various different levels of management.

		review of the suite of policies and review of the risk management framework These duties shall be done by the Acting Manager.	
	The director and centre management must ensure that the items identified for action from the personnel files are completed and the personnel files updated. The centre management team must ensure that they audit staff personnel files and staff training records on a regular basis.	Recommended action regarding the verification of references and evidence of training have been completed. These files are retained in the company office but can be viewed on request at the centre.	As previously stated above, an annual auditing schedule has been developed for staff training records The Centre manager and the director of operations will carry out auditing of the centre as required.
6	The centre management must ensure that the rosters are updated to contain the names of those who completed the shifts. The names of the identified current relief staff must be verified. The staff must ensure that they record the names of all on duty at handovers and in daily planning to ensure fire safety and daily accountability.	Rosters have been updated and contain all names of core staff who have completed shifts and the names of relief staff. This can be viewed at the centre office. All names of staff on duty are noted in the first section of the daily log. This also logs all outgoing and incoming staff. There is also a separate staff sign-in log noting arrival and departure times. This	Centre manager shall ensure strict oversight over the implementation of professional roster practices by weekly checks and this shall be logged in the weekly report. Centre manager shall ensure strict oversight over the accurate logging of staff on and off duty.

		log has been maintained from the start of the centre and can be viewed in the centre staff office.	