An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 086

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Streetline CLG**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**10th & 18th October 2020**
Registration Status:	**Registered from 31st of May 2020 to 31st of May 2023**
Inspection Team:	**Eileen Woods** **Lorraine Egan**
Date Report Issued:	**7th January 2020**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 31st of May 2002. At the time of this inspection the centre was in its seventh registration and was in year one of the cycle. The centre was registered without attached conditions from the 31st of May 2020 to the 31st of May 2023.

The centre, which is operated by a voluntary body, was registered historically to provide medium to long term care for four young males ages 14 to 17. The centre management and board agreed with Tusla in March 2020 to provide emergency accommodation in a temporary change to their purpose and function for the period of the pandemic response. The centre's revised temporary purpose and function commenced on the 01st of April 2020 and referrals for up to three young people, including sibling groups, aged 12 to 17 are accepted through the Tusla national out of hours' service. The approach to care was set out in guiding principles of supporting young people towards safety and stability through relationship with a staff team who are trained to understand developmental deficits, trauma and attachment difficulties. Over the course of the inspection days three young people had accessed the centre, one of whom had been living at the centre since July 2020 and a second since September 2020.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4
8: Use of Information	8.2

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the

inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 4th December 2020 and to the relevant social work departments on the 4th December 2020. 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 14th of December 2020. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 086 without attached conditions from the 31st of May 2020 to the 31st of May 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulations 5: Care Practices and Operational Policies
Regulation and 6 (1 and 2): Person in Charge

Theme 5: Leadership, Governance and Management

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

The centre was operated as a standalone voluntary body by a board of management and run day to day by a manager and staff team. The management team included a governance manager who supported the centre in meeting its regulatory, legislative, national policy and service level agreement commitments. Since the last inspection in 2019 significant development has taken place in policy and procedure implementation.

There was a main policy and procedure document, in its second tracked version, dated May 2020. There was a separate complementary policy suite developed to underpin compliance with the requirements of the Children First Act, 2015. These latter policies were dated April 2020 and were in their first version of development. Both sets of policies were well presented but where they referenced standards they were partially up to date. Inspectors found that some references still remained in the documents that related to the previous standards and this required revision to reflect the National Standards for Children's Residential Centres, 2018 (HIQA). Further policies were being completed at the time of this inspection and these included policies on record keeping, digital retention of files and safe communication of sensitive information. These have been forwarded to inspectors in order of completion.

The policy suite on child protection and safeguarding contained accurate details relating to reporting procedures as laid out within Children First: National Guidance for the Protection and Welfare of Children, 2017. Inspectors identified some details related to references and additional criteria required to make it more robust and bring it fully in line with the Children First. A list of policies identified as both required and as advisable, to reflect the National Standards for Children's Residential Centres 2018 (HIQA) was also identified to the management for inclusion into the

policy document. These included a policy on restrictive practices and a co-ordinated risk management framework to bring their current risk management approach together.

The staff team displayed good working knowledge of the framework for their work from the registration of the centre to compliance with the regulations, national legislation and policy as well as the centres polices and guiding principles. Ten new staff had been through a period of intensive practice induction at different times since January 2020 and through a change in the established purpose and function for all staff. This has required a necessary focus on the operational practices required to meet a new temporary purpose and function, therefore some procedures were more prominent than others, for example significant event reporting and safeguarding. Nineteen young people had accessed the centre since April 2020 and two young people living there at the time of the inspection told inspectors about their positive experience of the grounded care and support they received from the team.

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-cantered, safe and effective care and support.

The centre had an experienced long term manager. They were the named person in charge and were supported in their management role administratively by the governance manager and operationally in practice by a social care leader. A third part time person qualified and experienced to social care leader level provides senior cover during weekends. The tasks delegated to both the social care leaders were clear and named in structured protocols and staff and other professionals were aware of same. One of the social care leaders was the named person to cover periods of leave.

The centre as a standalone voluntary body had been in negotiations with Tusla regarding their service level agreement and reviewing options around amalgamation with another voluntary body since early 2019. The service level agreement remains under review and this has created uncertainty in particular impacting on recruitment and the management added that this extended to the retention of qualified staff, plus development and implementation of some processes and procedures. Inspectors found that this matter should be brought to a conclusion without undue delay to allow for the staffing and the development matters such as further policy work and external auditing to be fully resourced. The centre reports on compliance to Tusla on a yearly basis.

The centre manager had management meetings on a bi-monthly basis with the senior team and also met weekly with the social care leaders, in person, by phone call or virtually. There were records in place of the meetings. These mechanisms alongside daily oversight, a teaching and learning approach and bi monthly team meetings provided a clear framework for accountability and planning for day to day care. There was evidence of ongoing guidance in the provision of care. The governance manager and centre manager communicated on an ongoing basis.

The development of the policies and procedures was approached as a dynamic aspect of the work at the centre with reviews scheduled and updates made where changes were known about. The possible transition to a new umbrella voluntary body was being taken into account when considering further changes and a timeframe was pending for this. Throughout the process to date the centre management have executed policy and development work to reflect the particular ethos and principles of care at the centre.

The centre had an established set of procedures contained within individual policy areas leading their approach to risk management and inspectors recommend that these be co-ordinated into a framework of which lays out the risk identification, assessment and intervention approaches in place. A risk assessment matrix and protocol was introduced to staff at a team meeting in the summer but this has not been integrated fully yet in policy and records. Inspectors found that a set of guidelines for emergency admissions should be created. Inspectors found that the team had a pre admission emergency risk assessment form in place which was not utilised to its fullest extent to reflect what information it was possible to gather. Inspectors did find however that the team followed a set safety procedure for admissions and a protocol could capture this and allow for the outline structure to be better defined. The manager oversaw all risk assessment and safety plans put in place for the young people. The young people's files demonstrated the use of positive support plans, safety plans and individual risk management plans. Safe care was managed well and utilised all the available multidisciplinary resources inclusive of a robust advocacy approach for young people.

The centre management team responded to the Covid-19 pandemic in a co-ordinated manner, implementing planning and response from the emergence of the pandemic. The staff team had daily protocols in place for infection control measures and they had been provided with regular guidance from Tusla and their own management team when the national public health emergency team and governmental advice and requirements changed. Inspectors were informed that supplies of practical items

such as personal protective equipment which had up to recently been supplemented by Tusla were now the sole responsibility of the voluntary body representing a new cost to cover.

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

The centre provided inspectors with the temporary statement of purpose and function implemented from April 2020 alongside their core statement of purpose and function that they hope to resume post Covid-19. The statement was developed by the centre management and ratified by the board of management.

The document accurately reflected the aims and ethos through the principles of practice of the voluntary body and how this ethos was reflected through the standard of practices and model of care provided. The staffing arrangements in place to deliver this were also named in an attached organisational map in the main policy and procedure document. This should also be added to the temporary statement of purpose and function to note the manager plus eight staff posts in place. During this interim period with referrals arriving as emergencies, sometimes for as little for a few hours there was no opportunity to share a copy with many families or professionals. There were records on the files of contact with families, significant others and professionals in pursuit of identifying the centre to them and working towards a collaborative plan for the young people.

The staff team had all been inducted into the principles of care by the manager who was suitably qualified to do this work. There was evidence throughout team meetings, daily reflections, handovers and supervisions of ongoing teaching and the implementation of that learning in practice by the staff. Inspectors found that the staff were motivated by the approach to care and holding the view that in order for its full value to be available to young people that they stated that it would be valuable to offer longer periods in placement.

The manager and the team had reviewed the value and implementation of the model through review of outcomes, views of young people, views of the young adults who once lived there that visit regularly and through research into current developments in therapeutic child care. The centre also reviews progress through communication with the Tusla national out of hours, crisis intervention management.

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

The centre manager, assisted by the governance manager and the social care leaders, had established a system of internal oversight. There was evidence of the oversight of the quality of care, the safeguarding of the young people and the management supported the onward planning for good quality care for the young people utilising an emergency placement at the centre. The records at the centre evidenced action and advocacy for the young people.

The centre had initiated improvements in provision of inductions and probations for staff to track the staff capacity to provide good quality care. There was internal oversight of supervision and staff development was undertaken. The management had created a file auditing template for weekly oversight of records. Inspectors found that the template of the weekly file audits should be strengthened and aligned to a new template for file creation. The young people's files contained records of the staff and management work which were well organised but the overall intended structure was unclear and a template for file structure should be created. The centre did not have an external additional auditing option to date aside from their board of management and charities regulatory compliance measures. The chairperson of the board outlined for inspectors that audits have been developed to track areas relating to finance, Garda-vetting, induction processes, rotas, staff hours, mandatory training, supervision and appraisal, health and safety, safeguarding and child protection (to include a child protection register), and all other areas of operation of the centre, including a weekly file audit. They further stated that arrangements had been commenced to source an external social-care practitioner to audit care plans but that since the temporary move to the new purpose and function that the external system has yet to be put into operation.

The manager and the staff evidenced review of information related to complaints, incidents and concerns, in their management meetings and staff meeting, also through reports to the board of management. There was an internal significant event review group and actions were implemented. Outcomes from interventions were discussed within the team and all staff identified aspects of practice that they reviewed to meet the diverse needs of the group of young people accessing the emergency service. The manager maintained records of follow through on child protection reports notified through the Tusla portal system and had created a dedicated child protection reporting register. The staff team displayed good knowledge of the complaints policy and both young people who completed

questionnaires stated they knew how to make a complaint. There was a complaints register in place which noted two complaints in 2020 both of which were concluded. The policy on complaints required updating to reflect the Tusla Tell Us national complaints process that young people can access and to update some terminology within it. There was a version of the young people's booklet created for the temporary purpose and function and this contained information on complaints and rights.

The board of management outlined to inspectors their systems in place in order to satisfy compliance with the charities regulations and they had updated their constitution which was lodged with the office of the charities regulator. The governance manager and the centre manager drafted annual reports of compliance which were presented to the board for approval. The chairperson outlined the robust systems in place for compliance and named the boards positive view of the staff and management standard of care for children and young people. The centre also completes reports of compliance for Tusla.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.1** **Regulation 6.2**
Regulation not met	**None identified**

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

Actions required

- The centre manager and the governance manager must review the policy and procedures documents to update points of reference and identify gaps in policy provision in line with national guidelines, legislation, regulation and national standards for children's residential centres 2018 (HIQA).
- The centre manager and the governance manager must review the child protection policy document to ensure all advised complementary policies are in place in line with national guidance documents on Children First.

- The centre management must review centre auditing processes and devise a plan of action to expand this.

Regulations 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.

The centre had a staffing complement of a manager plus eight staff for the centre. The posts had been filled and there were adequate numbers of staff overall to cover all types of leave. There had been a period of time prior to 2020 where the centre had not recruited staff due to pending negotiations regarding the service level agreement with Tusla. Once it was agreed between the parties to review options for service provision in January 2020 and later to provide emergency placements for young people, a process of recruitment took place. As stated ten staff inclusive of a relief panel had started in 2020, not all have continued or been required for significant hours. There was evidence of the work force planning undertaken by the centre management whereby they recruited to cover all contingencies and needs, particularly taking account of the pandemic.

There was a blend of experience on the team although for many of those recruited this was a new type of service. There was a balance of social care qualified staff and two social care leaders, one full time and one-part time in post. There was evidence of the focus by the governance manager, who deals with recruitment and rostering, that all aspects of work force planning were of a high standard and created with the needs of the young people at its core.

The staff team named that they felt supported at the centre through the continuous learning approach, supervision, reflective practice and supports. They identified also that the nature of the provision of emergency placements for young people in crisis was demanding and that it was the type of supports they received that made this work possible, as stated earlier all staff advocated for the return to medium term work model.

There were formalised arrangements in place for the provision of on call supports during the evenings and weekends, this was shared between the manager and the

social care leaders. The staff were fully aware of the arrangements and utilised it appropriately in the context of the new purpose and function.

Standard 6.2 The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

The governance manager had ensured that the centre had policies and procedures for recruitment and vetting designed to meet the requirements of national guidelines and legislation. They had created and maintained securely a personnel file for each staff member. Inspectors reviewed a sample of five personnel files and following discussion with the management had identified some small gaps in the records stored for two copies of written references and the need to pursue the independent verification of all qualifications with the awarding colleges. Some files did have the verification and others had transcripts on file. The management stated that they had sourced the written references and would provide copies and evidence of same once placed on the relevant personnel files. They have committed to sourcing all independent verification of qualifications for newly recruited staff. All staff had the appropriate Garda vetting and overseas vetting required on their personnel files.

The staff in their interview and questionnaires outlined a structured and clear process of recruitment from application, to interview and onward to the provision of a job description and contract of employment. Staff had signed their contracts of employment and it was clear where staff moved from a relief contract to a full time post. All full-time staff had been made aware of the status of the service and that their continued contract was contingent on continued funding to the centre.

The staff had a written code of conduct and were aware of its content, the principles of practice also upheld professional standards expected of staff in the quality and nature of their expected engagement with young people.

The centre manager was suitably qualified and experienced with post graduate qualifications relevant to providing therapeutic guidance to the team, they also had a qualification in clinical supervision. The team spoke positively about the standard of guidance and leadership from the centre management.

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

The staff team demonstrated an understanding of their role to inspectors in their responses to the inspection. They had areas of learning that they had individually and as a group discussed and it was clearly named that the team had been expanded extensively in 2020. There were records to support that the staff were guided to be open and address any gaps in practice and knowledge. There was evidence that any issues arising in combining both a new team and a new purpose and function alongside an existing small long term core team were addressed in a safe manner.

The newer staff team members demonstrated that in the period of time since their recruitment that they had working knowledge of the principles and procedures expected of them and knew the standard of care that the centre wished to uphold. There was cohesion and agreement on what the objectives were in providing a place of safety and stabilisation for young people in crisis. The team had team meetings that included a dedicated education section, there had been group supervision sessions in the past and critical incident reviews as well as significant event reviews took place. Daily reflection and de-brief took place with the centre manager.

The centre management and the board of management have a health and safety subcommittee and they ensured that all matters related to health and safety regulatory and legislative requirements were up to date. There were scheduled health and safety audits outlined by the chairperson of the board in response to this inspection and actions taken and recorded on maintenance, fire safety and accidents or injuries.

The centre had a supervision policy in place, this named the timeframes for sessions as two monthly and the manager and social care leaders were trained in the provision of supervision, the manager was trained to post graduate level in the provision of clinical supervision. The centre manager was supervised by an external supervisor for professional practice and records were provided to inspectors of this. The centre supervision recording system contained templates for tracking sessions, for supervision agreements, confidentiality, accountability and templates for recording the sessions completed. The centre manager reviewed the supervision provided by the social care leaders. The sessions on file were broadly in line with the two monthly timeframes and the trackers were designed to identify any gaps and why they occurred. Overall the supervision records demonstrated a focus on key policies such

as key working and direct work with the young people, roles and responsibilities were covered with new staff in particular. There was evidence of support for any impact the work may have on the staff.
There was an appraisal policy and supporting documents in place to record the transition from inductions through to a yearly appraisal process. Although somewhat impacted by the response to the pandemic it was clear where performance and development was tracked.

The staff handbook outlined the availability of an employee assistance programme with options for confidential counselling. Inspectors found that staff were aware of the options open to them and expressed that there was open access to all forms of support.

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

The centre accesses training in their recognised method of management of challenging behaviour through Tusla. Prior to the pandemic training had been booked for the team in this but it had been cancelled by the centre due to a lack of availability of sufficient numbers to attend on the nominated days. This has resulted in the team not being trained or refreshed up to date in the model of management of challenging behaviour. There must be concerted efforts made to source this training as soon as possible for the whole team, in the interim it must be clearly noted as part of admissions and on individual crisis management plans that the staff are not presently certified up to date.

The centre manager and the governance manager had a training need analysis structured into a training outline for 2020 record and in their senior management team meetings. The staff had completed training in fire safety in 2019, Children First eLearning modules one, two and three in 2019 and 2020, some staff were still completing these. In 2019 the staff had received additional training from the Tusla regional Children First information and advice officers. Staff had been directed to the HSE online learning options on infection control and personal protective equipment management, the staff were also directed to complete eLearning modules from Tusla on general data protection regulation, GDPR. The gaps in training compliance were being identified and actions put in place around those that the management could source or resource themselves, for example in first aid.

Inspectors found that within the centre that there was a multi-layered approach to teaching and coaching for staff. There was evidence of good use of suitable resources online and in hard copy for staff to access. Staff stated that found that they were motivated and empowered in their practice by the ongoing learning. Inductions were completed through an induction policy and pack in place. The social care leaders implemented the inductions and the centre manager oversaw the progression within these. The governance manager oversaw compliance and timeframes for inductions and appraisal completion.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1** **Standard 6.2** **Standard 6.3**
Practices met the required standard in some respects only	**Standard 6.4**
Practices did not meet the required standard	**None identified.**

Actions required

- The centre management team must source bookings for full certified training in the chosen method of management of challenging behaviours.
- The centre management team must ensure that booking of fire safety and first aid training are renewed without undue delay.
- The centre management must verify that the outstanding items have been placed on the relevant files and that the process of verification of remaining qualifications for new staff commenced.

Regulation 17 Records

Theme 8: Use of Information

Standard 8.2 – Effective arrangements are in place for information governance and records management to deliver child-centred, safe and effective care and support.

The centre had policies relating to administrative files and case and care records, further policies were nearing completion on recording keeping, safe communication using password protection and retention of files. Inspectors found that information gathered was treated in a confidential manner and evidence supported that sharing of information on a young person took place when it was appropriate and safe to do so. The centre files contained the information that was available relevant to each young person's admission and timeframes for staying at the centre. The nature of the provision, as part of the national Tusla crisis intervention service, of emergency/short term placements resulted in some young person being present for only an overnight. The inspectors found that in those instances personal or confidential information that was not required was not saved to the files. The files were maintained at centres office in locked cabinets and all staff were made aware of procedures for safe storage of files. The staff team received feedback on their written records regarding the standard of detail, appropriate content and compliance with procedure.

Of the files reviewed inspectors saw two files for young people who stayed at the centre for two and four months respectively and their files had been expanded to reflect the level of service being provided as a short term placement. The records evidenced child centred care and support, there was planning and consultation with the young people, their families and their professionals including social workers. The files were up to date and accurate, daily logs were also maintained for each young person. There was evidence of oversight by the manager and the social care leaders on records. The files would benefit from a framework for file contents in line with the purpose and function. Inspectors also found that the improvements were required in the completion of some templates with full staff names and in the completion of all sections through to decisions made on the admission risk assessment forms.

Young people were offered access to their records and were included where they wished to be in creating plans at the centre. The centre manager had created a system of confidential storage of information for current young people. The centre had a record in place of all admissions in compliance with the requirement of the

relevant regulation, the centre manager was following up with the Tusla out of hours' social workers regarding some missing information for one entry into the register.

The centre had a policy on general data protection regulation, GDPR, created in April 2020, the policy references the Data Protection Act 2018 as part of that policy. All staff had completed e-learning training in GDPR in 2020. The centre were completing research into finalising a policy on managing requests for access to historical information. The files of previous young people who had lived at the centre were transported to the Tusla approved long term storage facility after one year and a log of what was archived was maintained by the centre.

Compliance with Regulation	
Regulation met	**Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**None identified (one standard examined)**
Practices met the required standard in some respects only	**Standard 8.2**
Practices did not meet the required standard	**None identified (one standard examined)**

Actions required

- The centre management must create a framework for the file contents taking account of the temporary purpose and function. All staff must complete the necessary documents for admissions and demonstrate the decision making process in place.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The centre manager and the governance manager must review the policy and procedures documents to update points of reference and identify gaps in policy provision in line with national guidelines, legislation, regulation and national standards for children's residential centres HIQA, 2018.	All policy and procedures documents will be reviewed and updated in relation to points of reference and to identify any gaps by end of January 2021.	When developing new policies and procedures, all points of references will be checked by 2 people.
	The centre manager and the governance manager must review the child protection policy document to ensure all advised complementary policies are in place in line with national guidance documents on Children First.	We have taken all recommendations and advice into consideration and the following sections will be included in our current Child Safeguarding Policy and Procedure document by end January 2021: - Protected disclosures; restrictive practices; standalone risk assessment/safety plan (completed and copy provided to inspectors); Positive behaviour plan (completed) We have already included a risk	Will keep on the agenda of management meetings with ongoing review.

		assessment framework/matrix into our collective risk assessment (copy provided to inspectors). We will do up a policy on risk management and resolution (including escalation to external bodies). We will also do up a separate risk management policy with the full suite of risk management measures in the centre by end of Jan 2021.	
	The centre management must review centre auditing processes and devise a plan of action to expand this.	Weekly file auditing and weekly checks on the quality of care by a third party.	By documenting management handovers, daily reflection on risk, team meeting reviews.
6	The centre management team must source bookings for full certified training in the chosen method of management of challenging behaviours.	In relation to training in challenging behaviours. Although classroom TCI training was not available, all the team completed the Tusla-specific TCI modules (de-escalation) placed online by Tusla during the first lockdown, and training was given on a trauma-informed approach. The centre has a policy of no physical restraints. New online TCI modules were released on Nov 30th, 2020. All staff have now been made aware	Ongoing tracking of mandatory training.

		of the online 3- module TCI training and will complete it with view to completing any further Tusla requirements when they become possible with Covid restrictions.	
	The centre management team must ensure that booking of fire safety and first aid training are renewed without undue delay.	Fire safety training is ongoing, and First Aid Training is up to date for full-time staff. First-Aid training specific to centre, such as safe administration of medication is mandatory for all staff, and ligature training and any other centre-specific First Aid training will be sourced by March 2021.	Ongoing tracking and review of mandatory training.
	The centre management must verify that the outstanding items have been placed on the relevant files and that the process of verification of remaining qualifications for new staff commenced.	Any outstanding items have been placed on personnel files, and the process of verification of qualification will be completed by end January 2021.	Two-person check of all personnel files annually and request independent verification of qualifications prior to starting and added to files
8	The centre management must create a framework for the file contents taking account of the temporary purpose and function. All staff must complete the	We have revised the framework for the file contents, taking into account the temporary purpose and function (attached). We have also drafted a new	Ongoing review so that the framework matches our purpose and function.

	necessary documents for admissions and demonstrate the decision making process in place.	pre-admissions form using our own experience and with recommendations from other voluntaries working in emergencies. This is currently being used and will be reviewed again in February 2021 to see if any further changes need to be made. Our weekly file audit now ensures signatures are in full and ensure documentation of the decision-making process.	Continuing weekly file audits