An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 186

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Pathways Ireland**
Registered Capacity:	**Single Occupancy**
Type of Inspection:	**Announced**
Date of inspection:	**20th, 21st and 22nd April 2021**
Registration Status:	**Registered from 12th January 2021 to 12th January 2024**
Inspection Team:	**Sinead Tierney** **Linda McGuinness**
Date Report Issued:	**6th July 2021**

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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 12th of January 2021. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from the 12th of January 2021 to the 12th of January 2024.

The centre was registered to provide single occupancy of both genders from age thirteen to seventeen years on a medium to long term basis. At the time of inspection, there was one young person living in the centre aged under 12. Application for derogation was made in respect of the young person and approved. The work of the centre was underpinned by a therapeutic model of care built on a foundation of core values, principles, and theoretical approaches. There was a focus on attachment and trauma informed care, and the inclusion of the voice of the child.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors looked 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, carried out observations 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 consult with children and parents. In addition, 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.

Due to the emergence of COVID-19, this was a blended inspection of remote and onsite activity. It was carried out through a review of documentation, a number of online interviews and a visit to the centre to view the premises and meet the young person.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 14th of June 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 24th of June. 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: 186 without attached conditions from the 12th of January 2021 to the 12th of January 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

Inspectors found evidence of good safeguarding and child protection practices within the centre. The centre had the required polices and procedures in place and was operating and in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017.

A child safeguarding statement was in place and displayed appropriately, and there was written confirmation dated February 2021 from the Tusla Child Safeguarding Statement Compliance Unit that the statement was complaint with requirements of the Children's First Act, 2015. There was a risk assessment as required, and procedures in place to manage identified risks. A designated liaison person (DLP) and deputy DLP were named, and relevant training had been undertaken in relation to the responsibilities of this role. Inspectors saw evidence in centre records that child protection was discussed at team meetings, managers meeting, clinical therapeutic planning meetings and was reviewed as part of the centres audit framework. The centre had a list of mandated person's and staff were familiar with the contents of the Child Safeguarding Statement.

Organisational management were in the process of leading a review of all policies and procedures and ensuring policies were in line with National Standards for Children's Residential Centres, 2018 (HIQA). The organisation's child protection and safeguarding policy had been prioritised within this review with a training schedule for the team in the weeks post inspection provided to inspectors. Additional policy and procedure training modules were in design in consultation with the staff and training was to be provided to the staff team upon completion. A review of personnel files found that policies in respect of vetting practices were adhered to and all files contained the required documents.

There was a policy in place to address all forms of bullying in line with Children First: National Guidance of the Protection and Welfare of Children, 2017 and relevant legislation. A policy was in place in respect of electronic communication and

safeguarding young people online. The resident young person had no unsupervised access to the internet due to their age and developmental level.

Staff training records evidenced that each staff member had completed the Tulsa's E-Learning module: Introduction to Children First, 2017 as well as the organisational child safeguarding training. Inspectors found from interviews that while staff were familiar with child protection policies, they were less confident in regards their statutory obligations as mandated persons under the Children First Act, 2015 and may delay reporting a child protection and welfare concern whilst awaiting guidance from the DLP. However, the inspectors examined the register of child protection concerns and were satisfied that issues arising had been reported and managed appropriately.

There was good evidence of partnership in promoting the young person's safety and wellbeing as well as oversight of relevant centre records by the young person's social worker. The young person has recently received a visit from their social worker. From interview with the social worker and review of records, it was evident that copies of all relevant plans including the therapeutic plan, behaviour support plan and individual crisis support plan were sent to the social worker. In line with the National Policy on the placement of children aged 12 and under, monthly child in care reviews were scheduled and taking place. There was one child in care review that was delayed by two weeks however inspectors were satisfied that outside of this anomaly, meetings were taking place in line with requirements.

Inspectors found that regular communication was in place with parents and there were agreed procedures to inform parents of allegations of abuse. Records evidenced that the parent contributed to the child in care reviews and was informed of child safeguarding interventions in place.

There was evidence throughout the young person's records of individual work undertaken to develop understanding of their behaviour and support their growth and development. Examples of age-appropriate programmes completed with the young person included "stranger danger" and "safe touch". As the young person was not within a formal educational setting and received their education through the support of a tutor and staff, it is important that such programmes which are carried out in schools continue to be planned for.

A pre-admission risk assessment, impact risk assessment, safety plan and risk management plan were in place to identify and address areas of vulnerability, risk and identify safeguards. All staff in interview were able to name individual areas of vulnerability and the safeguards in place. There was further evidence of these areas discussed in team meetings, supervision records and clinical therapeutic planning meetings.

The centre had a protected disclosures policy and reporting templates to facilitate staff to raise concerns or disclose information relating to poor practice. Inspectors found that most staff members interviewed were familiar with the policy and the relevant legislation and would report concerns without fear of adverse consequences. However, one staff member named the grievance policy as the policy they would refer to if concerned about poor practice. The centre management must ensure that staff are aware of the correct policy to refer to with regards to concerns about poor practice.

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

The centre had a written policy on the management of behaviour with a focus on responding to behaviours from a strengths-based perspective. The young person in placement had complex needs and it was evident from interviews, observations, and records that several reward-based incentives and charts were in place. These incentives were age appropriate, clearly planned and reviewed with a focus on managing the environment using visual and transitional aids to support the young person in daily life and in the management of behaviour.

All staff had up to date training in a recognised model of behaviour management and were guided in their practice by an in-house trainer. The centre was further supported by a systemic psychotherapist who chaired regular clinical therapeutic planning meetings and was involved in the development and review of plans. These meetings also examined staff care and wellbeing and the impact of managing behaviour that challenges on the worker. An external agency who utilises a capacity building model, support both the young person and staff team with additional assessment and learning supports on a weekly basis. The team had recently undertaken specialist training with this service to improve their understanding of the young person's needs. All staff had completed training in the organisations model of care. There was evidence of the teams understanding of how the young person's

behaviour was impacted by trauma and strategies developed where in line with the model of care.

There were several plans in place aimed at assessing and understanding the needs of the young person and developing appropriate response strategies. The young person had a therapeutic plan, individual crisis support plan and behaviour support plan which were all found to be in aligned and supporting the team to understand and respond effectively to the young person's behaviour. There was evidence of a multi-disciplinary approach in the development of plans that had a focus on providing a safe and stable environment for the young person. Efforts to complete Life Space Interviews (LSI's) using creative communication approaches were recorded.

There was evidence both in interviews and review of records that staff had an in depth understanding of the vulnerabilities of the young person. This knowledge was developed in part through the range of plans in place that staff had signed on reading and good communication. Minutes of all multidisciplinary meetings were on file and up to date. Visual and transitional communication aids were in place to support both the young person and staff. Inspectors observed these aids in practice and found them to be creative and beneficial to the young person.

The centre had a multi-layered audit framework that included audits undertaken by the centre manager, service manager and the compliance and complaints manager. All of these were overseen by the director of services. Monthly organisational significant event review groups (SERG) meetings were held to discuss significant events for young people, share learning and identify trends. An individual absence management plan which was required under the *Children Missing from Care: A Joint protocol between An Garda Síochána and the Health Services Executive, Children and Family Services, 2012'* was in place.

The centre had a policy on restrictive practice coupled with a register, notice of restrictive practice recording and review system. Evidence from interviews and a review of records demonstrated the centre's implementation of restrictive practices was motivated by the desire to safeguard and protect the welfare of the young person, the care team and others. The notice of restrictive practice documented the purpose of the practice, the commencement, review date and outcome of review. Inspectors found the practices in place related to the safety of the young person and were appropriate to their needs. There was evidence of oversight by external management, the young person's social worker and discussions at child in care reviews attended by

the parent. There had been no use of physical interventions since the young person was admitted to the centre.

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

Inspectors found that an open culture was promoted in the centre with evidence of both the young person and staff members encouraged to raise concerns and identify areas of improvement. Both incidents of concern and positive developments were shared with the team in handovers, supervisions, and team meetings. On admission, the young person was provided with the telephone number and a stamped address envelope with the address of the director of services if they wished to raise concerns. During interview, staff reported management as accessible and approachable. The centre should consider if an alternative method of communication can be provided given the young age and needs of the child.

The child in care review meetings and regular communication methods were the primary mechanisms in place for the social worker and parent to provide feedback and identify areas for improvement. Recent areas discussed related to the young persons education and efforts were on-going by the social worker to secure an appropriate school.

The inspectors found that the centre had a written policy and procedure for the recording and notification of significant events that was clearly articulated by staff members during interview. A review of records confirmed that the policy and procedure was followed. During interview, the supervising social worker stated that notifications of incidents were received in a timely manner, were detailed, well-structured and provided a clear picture of how the incident was managed and what happened.

The centre manager and external management team received live notification of incidents from their software system which allowed them to respond efficiently if required. There was evidence of relevant records signed but not always dated by the service manager and director of services. A review of the significant event register found that there were periods of daily incidents for the young person. These incidents were mostly behaviours that the young person engaged in to try self-regulate, communicate and express their emotions. There was good evidence that plans were updated following new or an escalation of behaviours and were done so by involving all relevant people and services. The register allowed for entries if the young person or staff members were injured. However, from a cross-comparison of

notifications and the register, injuries which had occurred to both the young person and staff had not been recorded on the register.

The organisation's compliance and complaints manager chaired the significant event review (SERG) meetings, and these were attended by senior management, centre management and deputies. The meetings took place monthly and a review a meetings minutes evidenced good attendance and detailed discussions. Both significant events and complaints were discussed with learning outcomes and emerging trends identified. There was no policy related to SERG meetings and the director of services had undertaken a review in 2020 and identified areas of improvement. The review highlighted that meetings could benefit from further improvement to ensure that meetings maintained their intended focus.

Staff members at interview, the supervising social worker and centre records confirmed that learning was communicated back to them following SERG meetings and that young person's plans were updated promptly if required.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The director of services and the centre manager must ensure that the updated child protection policy is communicated to all staff and training undertaken.
- The director of services and the centre manager must assure themselves that all staff members fully understand their statutory responsibilities as mandated person's.
- The director of services and the centre manager must assure themselves that all staff members are familiar with the centres protected disclosure policy.
- The centre manager must ensure that all sections of the register of significant events are completed and injuries sustained by young people or staff recorded.

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

Theme 5: Leadership, Governance and Management

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

The organisation had policies and procedures and was in the process of revising to ensure full compliance with regulations and the National Standards for Children's Residential Centres, 2018 (HIQA). A working group was established for this purpose, chaired by the development manager, and overseen by the director of services. A suite of accompanying training modules was in draft form and mechanisms in place for staff members to provide feedback on the revised polices and training modules. There was evidence of discussions at team and management meetings relating to policies and procedures and updates from the policy development working group.

An audit framework was in place that included thematic audits undertaken by the centre manager, service manager and the compliance and complaints manager. These audits were conducted monthly and overseen by the director of services. The centre manager and deputy manager had audited the centre against all themes under the National Standards for Children's Residential Centres, 2018 (HIQA), in the first four months of 2021. No actions plans were included in this auditing template thus making it difficult for inspectors to assess the impact of the findings on practice and service provision. It is recommended that the centre include an action plan following the completion of centre audits.

The service manager and compliance and complaints manager further undertook thematic monthly audits. The findings of these audits were informed via consultation with the young person, centre observations, a review of records and communication with management. There was no evidence that staff members were engaged as part of these audits. The compliance reports contained identifiable information related to the young person and some data was inaccurate. The director of services should ensure that no identifiable data related to young people are contained in compliance reports and the General Data Protection Regulations, 2018 principles of data minimisation and accuracy are complied with.

Through interview and review of questionnaires, inspectors found that the centre manager and staff were aware of centre policies and procedures and relevant legislation and how these informed practice in the centre. As mentioned previously, some staff members at interview were less confident in articulating their statutory obligations as mandated person's and the centres whistleblowing policy. Overall a commitment to evidence informed practice in caring for the young person was demonstrated to the inspectors.

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 found strong evidence of leadership and management within the centre. Confidence in the manager was expressed by staff and senior management in interview and questionnaires. The manager played a central role in the development of plans for the young person in conjunction with others and these plans supported a safe environment for the young person. The young person's social worker stated in interview that the centre was well managed with a high-quality level of care provided to the young person.

There were clearly defined governance arrangements and structures in place with clear lines of authority and individual accountability. The centre manager had been in an acting position since the centre's registration following their internal transfer from another centre and reported directly to the service manager. The service manager had joined the organisation two months prior to the inspection and demonstrated a good range of knowledge about the young person, the centre practices, and wider organisational systems. The service manager reported to the director of services, who had overall oversight responsibility for the centre. The director of services visited the centre on a weekly basis and had up to date knowledge on matters relating to the young person and staff members. They demonstrate a high level of commitment in interview to providing quality care to the young person, supporting the manager and team in applying the model of care, and creating an inclusive working environment for staff members. All levels of management and staff had job descriptions appropriate to their positions and displayed a good understanding of their specific roles and responsibilities.

There was a service level agreement in place with the Child and Family Agency and meetings took place as required.

There was a risk management framework in place that included individual risk assessments for young people, a centre risk register and organisational risk register. Individual risk assessments were recorded for the young person and relevant support plans updated following these. The centre manager and senior management received instant notification of risks from their software system and there was evidence that responses were timely.

The organisation had recently updated the centre and organisational risk registers to include the impact/likelihood risk matrix. Minutes from team and management meeting evidenced discussion regarding the risk matrix however inspectors found that not all staff members were aligned in their understanding of how it was to be used. Differing information was provided during interviews as to whom had authority to input data into the register. Although the level of information entered was comprehensive, data was entered that did not match the subject headings and there was no evidence as to how a risk rating level was decided upon. For example, an identified risk with a rating of four was entered into the centre register. The risk matrix allowed for three different scoring combinations to achieve a rating of four. There was no system in place to determine which impact/ likelihood combination was used and ultimately how the final risk level was decided upon.

Inspectors assessed the centres response to the management of risks posed by the Covid-19 pandemic. The centre had a detailed crisis management plan in place and had adapted the centre procedures and practices to comply fully with public health protection measures.

There was a delegation of duties form in place to record managerial duties delegated to the deputy manager in the absence of the manager. There was a qualified and experienced deputy manager in post whose working time was split between direct work and supervision of the young person and administrative and supervisory duties related to the team and centre. The inspectors were concerned that there were insufficient hours available to the deputy to effectively discharge their administrative and supervisory tasks. The director of service notified inspectors prior to the completion of the report, that the deputy managers hours had been evaluated and changed to ensure sufficient time was allocated. The centre manager should ensure that when the deputy manager is working directly with the young person, their hours are recorded in the centre roster for transparency purposes.

There was a system in place to support staff members in the centre in managing risks or incidents outside of office hours. On call arrangements were in place and covered

one other centre within the organisation. On call was shared by both centre's managers, deputy managers and social care leaders.

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

The centres statement of purpose and function was created in January 2021 by the centre manager and director of services and was reviewed annually or as required. It outlined the aims, objectives and ethos of the service, the care and support needs of young people, the services, and facilities available to young people. The management, staffing and governance structure and an overview of the model of care were also included.

An understanding of the model of care as outlined in the statement of purpose was demonstrated by staff members during interview and was reflected in the planning and daily care of the young person. The statement of purpose was available in an accessible format to young people, parents, and guardians.

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.

Inspectors found that the quality, safety, and continuity of care provided to the young person within the centre was regularly reviewed to inform improvements in practices and to achieve outcomes for the young person. In preparation for the admission of the young person, staff members that were known to the young person were assigned to the centre to provide a level of stability for the young person. The centre staff and management were creative in their efforts to review their practice, monitor what was working well and not so well with the young person and identify gaps or barriers in supporting the young person. The centre was supported by the behaviour management trainer, systemic psychotherapist, and an external specialist service in regularly reviewing the quality of care and this was evidenced in meeting minutes.

There was evidence the centre manager, service manager and compliance and complaints manager monitored the quality of care in the centre through regular auditing of practices. These audits had been mapped to the National Standards for Children's Residential Centres, 2018 (HIQA) with evidence that actions had been identified by external management and addressed in a timely manner by the centre manager.

A complaints policy and procedure were in place and being updated at the time of inspection. An up-to-date complaints register was in place. The centre had amended the complaints procedure following a multi-disciplinary assessment of the language used by the young person. The amended procedure aimed to identify, review, and respond to trends in communication and potential complaints. The centre reviewed the language used by the young person on a weekly basis to assist them in differentiating between a complaint and the young person's way of communicating or inability to appropriately verbalise their feeling. The inspectors found good evidence of complaint review and management on record however the outcome of complaints did not indicate if complaints were upheld or not.

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

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

Actions required

- The director of services must ensure that no identifiable information related to young people are contained in compliance report.
- The director of services must ensure that the risk management policy clearly identifies how the risk rating is reached using the risk matrix.
- The director of services must ensure that clarity be provided to all staff members on whom has authorisation to enter data into the risk register and include this in the policy and procedure documents.
- The centre manager must record the deputy manager as part of the rostering record when they are rostered to work directly with the young person.

- The centre manager must ensure that the records state whether a complaint was upheld or not and the full outcome of complaints is recorded in relevant documentation and the complaint register.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director of services and the centre manager must ensure that the updated child protection policy is communicated to all staff and training undertaken.	The centre management team and the care team received training on the updated child protection policy on 10/02/2021 and will continue to receive annual training and/or as required. The child protection policy will continue to be reviewed in the team meetings.	The service director and the centre manager will continue to review the child protection policy annually and/or as required. Should the policy be updated the care team will receive appropriate training to ensure all staff members are aware of any updates to the policy.
	The director of services and the centre manager must assure themselves that all staff members fully understand their statutory responsibilities as mandated person's.	The centre management team and the care team received training on the updated child protection policy on 10/02/2021 to ensure all staff members fully understand their statutory responsibilities as mandated person's. The policy was further reviewed in the centres team meeting on 17/06/2021.	The centre manager will ensure to review the child protection policy regularly in their staff meetings to ensure all staff members fully understand their statutory responsibilities as mandated person's. All staff members receive annual child protection training.
	The director of services and the centre manager must assure themselves that all staff members are familiar with the	The centre manager reviewed the employee handbook specifically the whistleblowing policy on 17/06/2021 with	The service director ensures as part of staff members induction programme that they receive their employee handbook with key

	centres whistleblowing policy.	the care team to ensure all staff members are familiar with the centres whistleblowing policy.	policies identified, one being the whistleblowing policy and receive training on the whistleblowing policy as part of the corporate induction before commencing work in the centre. The whistleblowing policy will continue to be reviewed regularly in the team meetings.
	The centre manager must ensure that all sections of the register of significant events are completed.	The centre manager will ensure all sections of the register of significant events are completed. The centre management team reviewed the significant events registers on 29/04/2021 to ensure all sections were updated.	The centre management team will continue to review the centre registers on a weekly basis and ensure all sections of the register of significant events are completed.
5	The director of services must ensure that no identifiable information related to young people are contained in compliance report.	The service director met with the compliance and complaints officer on 18/06/2021 and agreed that no identifiable information related to young people are contained in compliance reports.	The service director will continue to review all compliance reports before dissemination to the centre to ensure that no identifiable information related to young people are contained in compliance report.
	The director of services must ensure that the risk management policy clearly identifies how the risk rating is reached using the risk matrix.	The service director with the service manager and development manager updated the risk management policy to clearly identify how the risk rating is	The management and care teams will continue to receive annual training on the risk management policy and all new staff will receive training at their corporate

		reached using the risk matrix. Completed 21/06/2021.	induction.
	The director of services must ensure that clarity be provided to all staff members on whom has authorisation to enter data into the risk register and include this in the policy and procedure documents.	The service director updated the Risk Management Policy on 18/06/2021 to ensure all staff members are aware of whom has authorisation to enter data into the risk register.	The service director and centre manager will continue to review and update the Policy and Procedure document annually and or as required.
	The centre manager must record the deputy manager as part of the rostering record when they are rostered to work directly with the young person.	The centre manager has updated the roster document and the deputy managers hours are inserted onto same whey they are working directly with the young person.	The centre manager going forward will ensure to include the deputy managers hours onto the roster when they are working directly with the young person.
	The centre manager must ensure that the full outcome of complaints is recorded in relevant documentation and the complaint register.	The centre management team review all complaints on a weekly basis and will ensure the full outcome of complaints is recorded in the complaint register.	The centre management team will continue to review the complaints register and relevant documentation to ensure the full outcome of complaints is recorded in the complaint register.