An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 015

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Positive Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**12th, 13th, 14th April 2021**
Registration Status:	**Registered from the 9th September 2019 to the 9th September 2022**
Inspection Team:	**Joanne Cogley** **Anne McEvoy**
Date Report Issued:	**19th October 2021**

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 in 2010. At the time of this inspection the centre was in its fourth registration and was in year two of the cycle. The centre was registered without attached conditions from 09th September 2019 to the 09th September 2022.

The centre was registered to provide care for four young people between the ages of thirteen and seventeen upon admission. The centre operated under a "care framework" which outlined the principles of therapeutic approaches and models which should underpin placements and overall therapeutic care. The care framework was relationship based and had four pillars: entry; stabilise and plan; support and relationship building; and exit. This model included work on trauma and family relationships while setting meaningful life goals for the young person. There was an emphasis on understanding the young person's behaviour and helping them to learn healthy alternatives. There were four young people in residence at the time of 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, 3.3
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1, 6.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, 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 22nd July 2021 and to the relevant social work departments on the 22nd July 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 5th August 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 015 without attached conditions from the 09th of September 2019 to the 09th of September 2022 pursuant to Part VIII, 1991 Child Care Act.

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 personal development.

At the time of inspection there were four young people residing in the centre. All young people had up-to-date care plans on file and review meetings were occurring in line with requirements. Inspectors saw evidence on file of young people being encouraged to attend their review meetings and where they chose not to, work was done with them in advance to ensure their views were represented at the meeting and their voices heard and feedback was provided after the meeting.

Each young person had an up to date placement plan on file that was prepared by the centre manager and updated by the keyworker. These placement plans incorporated goals from the care plan and were drafted on a quarterly basis. Inspectors found placement plans to be reflective of the care plans and linked to individual work being completed with the young people. Social workers interviewed confirmed that the placement plans supported the aims and objectives of the care plan. There was also evidence of individual work records being completed with young people that focused on the goals they wished to achieve for the month ahead and this was then incorporated into the placement plan. Inspectors offered to speak with all young people but only one young person chose to do so. This young person was aware of the long term planning for them and confirmed they had input into this. Inspectors spoke with one parent who confirmed they had the opportunity to provide input into their child's care and goals for their placement also.

Inspectors found each of the young people had access to the appropriate specialist services they required. There was evidence that young people were facilitated to attend specialist supportive services such as therapy and counselling, CAMHS and local youth group services. The centre had a psychologist attached to the service and they were available to work directly with the young people and also with team members to support them in their work with the young people.

Inspectors found from a review of care files, social work questionnaires and interviews with social workers, a guardian ad litum, centre management and staff that there was effective communication between all parties.

Compliance with Regulation	
Regulation met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Standard 2.2**
Practices met the required standard in some respects only	**Not all standards were reviewed**
Practices did not meet the required standard	**Not all standards were reviewed**

- **No actions required**

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.

Inspectors reviewed centre records and spoke with staff members and found there to be a positive approach towards behaviour management within the centre. All staff members interviewered were aware of the centres policy on the approach to behaviour management. There was evidence of the implementation of both sanctions and rewards. Inspectors also saw evidence that where young people were engaged in challenging behaviour, if they managed their emotions and regulated successfully they were rewarded instead of sanctioned. Inspectors also saw evidence of positive significant events being reported for young people. Professionals interviewed as part of the inspection process confirmed the centre had a positive approach to behaviour management and were notified of all issues within the centre in a prompt manner.

All staff were trained in a recognised model of behaviour management. Refresher training had been provided throughout the Covid-19 pandemic however only in the theory aspects of this training. There had been a lapse in the physical aspects of this training for some staff members. Two staff members were involved in a physical

restraint in February 2021 with a young person. At the time of the incident one of these staff members had not received training in physical restraint and the second staff member had not received refresher training in physical restraint since December 2019. While inspectors saw evidence of a qualitative and critical analysis of this incident, the lapse in training did not form part of this review piece. This is further addressed under Standard 6.4 in this report.
All staff members were subsequently trained in the physical aspects of a recognised behaviour management model in early March 2021 in response to this incident and following requests for training from the staff team in a team meeting.

The centre had an anti-bullying policy in place that staff were familiar with. Inspectors saw evidence that young persons meetings discussed expectations, house rules and how to treat each other within the centre. While there was one complaint on file from a young person in relation to potential bullying, there was evidence that this had been addressed immediately and reparative work completed. The young persons guardian ad litem confirmed they had no concern in relation to bullying and the social workers for two other young people confirmed there was no concerns in relation to bullying within the centre.

Evidence was available to show that each child was supported to develop their understanding of behaviour that challenges. This was completed through life space interviews (LSI's) after incidents of challenging behaviour. These LSI's were then linked to keyworking sessions in which anger management programmes were completed with young people. In one case during the month of December 2020 where a young persons behaviour escalated to levels of concern the centre provided additional staffing in order to support the young person pending their move to a new placement.

Each young person had an Individual Crisis Management Plan (ICMP) on file which recorded current behaviours, triggers, high risk behaviours and safety concerns along with de-escalation strategies. Inspectors noted at the time of inspection that one of the ICMPs had not been updated to remove reference to a restrictive practice no longer in use. The ICMP should be updated to reflect changes in restrictive practices.

The centre had a number of auditing systems in place which included a review of behaviour management in the centre. Inspectors reviewed a sample of these audits and were satisfied that there were appropriate internal and external mechanisms in place to ensure there was sufficient oversight of the centres approach to managing behaviour.

The centre had a written policy on the use of restrictive procedures. At the time of the inspection there were two restrictive procedures in place which were the use of bedroom door alarms at night-time and the use of physical restraint. Inspectors found that restrictive practices were documented in the young people's care records. While management and staff in interview were aware of the restrictive practices in place and were able to communicate the review process, there was little written evidence to support risk assessments and reviews occurring. This was raised with the regional manager at the time of inspection who identified it as an issue and had incorporated it into the weekly management agenda moving forward to ensure documented discussions and reviews. While social workers were aware and in agreement with the current restrictive practices in place, one guardian ad litem was not aware of the use of door alarms. The centre manager must ensure that guardians ad litem are kept updated on the use of restrictive practises in the centre.

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

Inspectors were satisfied that an open culture was promoted in the centre. Inspectors found that young people's meetings were held regularly and the young people were supported by staff and managers to raise concerns, express their views and have their voices heard. Inspectors spoke with one young person and reviewed two young people's questionnaires and found they could identify members of staff that they could speak with if they had an issue or concern. They reported that they were aware of the centres complaints process and had received responses to complaints raised. Staff in interview stated there was an open culture in the centre and expressed confidence in centre management.

There was evidence across a range of records including care plans and placement plans that the centre consulted and sought feedback from parents, social workers and other relevant professionals to determine their views on the quality of care being provided. The centre maintained appropriate contact with families through telephone contact and facilitated family visits. Social workers interviewed stated that the centre management liaised with them regularly and they were satisfied with the progress the young people had made in their placements. Inspectors spoke with one parent who noted the significant progress their child had made since moving to the centre and felt included in all aspects of their care planning. The regional manager stated that an online survey link had recently been sent to all social workers and the organisation intended to collate the feedback from these surveys and use them to inform improvements in the service in the second half of 2021.

The centre had a policy on the notification, management and review of incidents and inspectors were informed by social workers and guardian ad litem that all incidents were reported in a prompt manner both via phone and e-mail. There was evidence of oversight by the manager and regional manager who reviewed and commented on the management of all incidents. Incidents were discussed at team meetings and in staff supervision and learning was communicated to the staff team. Inspectors saw evidence of two recent SERG (significant event review group) meetings where approaches were reviewed, risk was discussed and alternative supports implemented for young people and staff.

Compliance with Regulation	
Regulation met /not met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.3** **Standard 3.2**
Practices met the required standard in some respects only	**Not all standards were reviewed**
Practices did not meet the required standard	**Not all standards were reviewed**

Actions required

- The centre manager must ensure that guardians ad litem are kept updated on the use of restrictive practises in the centre.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The centre manager and deputy manager were experienced in their role and had appropriate qualifications to hold the posts. During the course of the inspection it was evident that leadership was demonstrated by the centre manager. This was supported through interview with the staff members who stated that the centre manager was knowledgeable, approachable and very committed. Inspectors found

evidence of leadership on reviewing documents within the centre, where centre manager comments were clear, challenging of practice and supportive of staff efforts.

There were clearly defined governance arrangements and structures within the centre. All staff interviewed were aware of all management levels within the organisation and were clear on their respective roles and responsibilities. Understanding of roles and responsibilities had formed discussions in recent team meetings. All staff members interviewed confirmed they had received job descriptions and contracts. There was a record of designated task lists advising of duties appropriately delegated to staff members within the centre. The centre manager held the overall executive accountability for the delivery of service and it was evident from audits and documents examined that they had oversight on all areas of practice.

The centres policies and procedures presented for inspection were updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence of an on-going review of policies and procedures by both the organisation and by external consultants. Staff members had received refresher training in the centres policies and procedures in February 2021.

The centre had a risk management framework in place for the identification assessment and management of risk. The centre maintained a risk management folder in which specific risks were identified and assessed. While staff and management demonstrated a good knowledge of risk associated with young people in the centre, they struggled to identify in interview centre specific risks. The organisation policy on risk management categorised risk into three areas, corporate, centre and young people risks. Through interview neither the regional manager or centre manager were aware of items identified and held on the corporate risk register and stated this was held by the CEO of the company. The centre risk register was attached to the statement of purpose for the centre. From review of this risk register, risks identified and assessed were generic risks and were not centre specific. There was no mention of risks in relation to recent decisions for example, due to Covid-19 staff training being put on hold in the physical elements of a recognised model of behaviour management and the decision to reduce staffing levels within the centre. This reduction in staffing is discussed further under Standard 6.1. The centre manager and regional manager must satisfy themselves that they are aware of all risks pertaining to the centre. They must also ensure that risk assessments address risks specific to the centre and not just generic risks.

The centre's internal management structure consisted of one centre manager, one deputy manager and a social care leader. This management structure was appropriate to the size and purpose and function of the centre. The centre had procedures in place for designated people to contact in case of an emergency and operated an effective on call system.

The regional manager confirmed there were appropriate service level agreements in place and that annual reports were provided to the funding body.

Inspectors spoke with the centre manager and staff in relation to the ongoing Covid-19 pandemic and found evidence of a number of measures that were put in place by the organisation in response to the crisis. Staff members confirmed they had full access to personal protective equipment, cleaning materials and sanitiser as required. Staff stated they felt safe in their place of employment.

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

Compliance with standards	
Practices met the required standard	**Not all standards were reviewed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards were reviewed**

Actions required

- The centre manager and regional manager must satisfy themselves that they are aware of all risks pertaining to the centre. They must also ensure that risk assessments address risks specific to the centre and not just generic risks.

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 reviewed weekly management meeting minutes and found there to be a standing agenda that incorporated staffing needs. Through this any needs were identified and there was evidence of follow up on recruitment processes, contracts, vetting etc for the centre. At the time of this inspection there were ten full time contracted staff members. Nine of these staff members were qualified in social care or a relevant equivalent while one staff member did not hold a relevant qualification. This staff member had worked in the centre for three years at the time of inspection and inspectors were informed it was their intention to begin a social care qualification in the 2021 / 2022 academic year. Post inspection inspectors were provided with evidence of confirmation for acceptance to a recognised course for the next academic year.

From a review of staffing information submitted there was a mix of experience evident on the team. Three staff members had worked in the centre over four years, two staff members had worked in the centre over two years and the remaining staff had worked in the centre for approximately six months to one year prior to inspection. The centre had a turnover of five staff since the last inspection in July 2020. Two of these staff members transferred to another unit, two staff members left the organisation and one staff member returned to the relief panel. While there was evidence of an appropriate exit interview template in place, there was no evidence to show that these had been completed with the staff members who left to inform learning for the organisation. There were disparities in management interviews as to whose role it was to complete these exit interviews and whether or not attempts were made to complete them. The regional manager must ensure there is a system in place for exit interviews to be completed with staff members and that these are used to inform learning and development within the centre and organisation.

Management informed inspectors staffing arrangements in the centre provided for three staff to four young people (3:4) at any given time however it was noted with inspectors at interview that there were two exceptions to this. These exceptions occurred in the months of December 2020 and January 2021. In December 2020

due to a young person in placement requiring additional support for a period of time, an additional staff member was assigned in the evenings to ensure this young person was supported through ending their placement that month. In January 2021 inspectors were informed that a decision was made by the regional manager to reduce staffing in the centre to two staff daily. The rationale for this decision was due to the rising number of Covid-19 infections within the county the centre was located in, along with Covid-19 outbreaks in two out of the three other centres within the region. The aim was to reduce footfall passing through the centre. The regional manager could not state whether or not this decision had been taken nationally within the company and was only focused and aware of this decision in their own region. Inspectors spoke with two social workers and one guardian ad litem to ascertain their views. The guardian ad litem stated they were not informed of this decision and subsequently was alerted to it after raising a query with the centre manager. The social workers were aware of the decision however did not deem it a consultation process and stated they were sent a risk assessment via email outlining the decision. Social workers did state they were satisfied that should they have raised an objection or a concern then they believed the agreed staffing quotas would be reinstated. Social workers were of the opinion this reduction at the time did not impact on the care being provided to the young people. Inspectors reviewed the risk assessment and noted that it was a general health and safety risk assessment and did not assess the risks posed by a reduction in staffing on the care of the young people. The regional manager must ensure that any risk assessment in relation to a reduction of staffing includes an assessment of the risks posed to the care of the young people. During interview neither the centre manager nor the regional manager were aware as to whether or not the Tusla National Private Placement Team had been informed of the decision to reduce staffing.

Inspectors reviewed a sample of rotas and centre clock cards for a period from December 2020 to March 2021. From a review of these rotas it was evident that no relief workers passed through the centre in January 2021 however the application of reducing to two staff daily for reasons of Covid control measures was not consistently applied across the month. Seventeen days in January had reduced staffing whereas fourteen days of the month remained on the accurate staffing ratios. In the four month period reviewed there was an average of eleven relief staff members working in the house each month with the exception of January. This was additional to the ten contracted staff members. In addition to the decision to reduce to two staff members in January, there were four days in February in which the centre operated outside of its staffing ratio of 3:4. December and March rotas and clockcards showed the centre operated effectively within its staffing ratios.

Inspectors noted from a review of rotas that it included shifts assigned to one staff member who had not presented for work in the centre. It was confirmed by the centre manager that these shifts were assigned as sick leave and this staff member had subsequently left the company. The rosters provided had not been altered to reflect the sick leave of this staff member. It was also noted in a managers meeting on the 6th April 2021 that the regional manager informed unit managers of the importance of up to date rosters and to ensure any staff shortages were alerted to senior managers immediately. Also noted in this same meeting was that all rosters were to be filtered by the regional manager and/or client service manager prior to submitting any information to the inspectorate. Inspectors spoke with staff members, one young person, one parent, two social workers and one guardian ad litem, they also reviewed social work questionnaires and young persons questionnaires and found that while the decision to reduce staffing had not had consultation or appropriate risk assessments, there was no evidence of impact on the young people residing in the centre at the time. Young people continued to engage in online forums of education and access, based on each young persons needs, was facilitated. The regional manager and centre manager must ensure any changes to staffing are made in a consultative manner with social workers and also must ensure that staffing arrangements reflect the agreed staffing allocation agreed and funded by the national private placement team.

The organisation had arrangements in place to promote staff retention. They provided training, education assistance funding, access to healthcare packages and an employee assistance programme.

There was a formal on call policy and procedure in operation which staff stated was accessible and responsive to their needs.

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

The organisation provided a range of training and development opportunities to all staff members that were appropriate to their role. Along with the required mandatory training, training was provided in additional areas such as placement planning, drug awareness, attachment, medication management, keyworking and the organisations policies and procedures. All staff members training certificates were stored on their personnel file.

It was noted that the ongoing Covid-19 pandemic has impacted negatively on the provision of practical elements of training. Training in the physical restraint element of a recongised model of behaviour management and the physical element of first aid had been suspended for a prolonged period of time. The training in the physical restraint element was reinstated following a significant event in February 2021. The organisation should review their provision of the physical elements of training programmes and plan for these to be carried out in a safe manner moving forward.

Inspectors noted from a review of team meeting minutes that they were a forum for learning and development. Elements of training and policy reviews were incorporated into these meetings. Evidence was available to show the organisations training department, clinical department and regional manager all had input into meetings for training and developmental purposes and these meetings were well attended. Staff members interviewed confirmed that the training department had oversight on all training needs and would inform staff members three months in advance of renewal dates for booking training. The regional manager and centre manager maintained oversight of training needs within the team through an online system which identified areas staff were yet to be trained in or needed refresher training.

There was a formal induction policy in place. New staff members attended an organisational induction and training programme over the course of five days. They also then completed a house specific induction prior to commencing their first shift. Inspectors reviewed the in house inductions for the most recent three employees and found these to have been comprehensively carried out by the centre manager. In one instance a staff member had commenced employment in early 2021 and was yet to complete training in first aid and manual handling. This was in contrast to the organisations induction policy which states this training must be completed prior to joining the organisation. The regional manager must ensure all training is carried out in line with the organisations induction policy.

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

Compliance with standards	
Practices met the required standard	**Not all standards were reviewed**
Practices met the required standard in some respects only	**Standard 6.1** **Standard 6.4**
Practices did not meet the required standard	**Not all standards were reviewed**

Actions required

- The regional manager must ensure there is a system in place for exit interviews to be completed with staff members and that these are used to inform learning and development within the centre and organisation.
- The regional manager must ensure that any risk assessment in relation to a reduction of staffing must include an assessment of the risks posed to the care of each of the young people.
- The regional manager and centre manager must ensure any changes to staffing are made in a consultative manner with social workers and also must ensure that staffing arrangements reflect the agreed staffing allocation as agreed and funded by the national private placement team.
- The regional manager must review the provision of the physical elements of training programmes and plan for this training to be carried out in a safe manner moving forward.
- The regional manager must ensure all training is carried out in line with the organisations induction policy.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	No action required		
3	The centre manager must ensure that guardians ad litem are kept updated on the use of restrictive practices in the centre.	All guardians have been updated in relation to any restrictive practices in place.	Guardian ad Litems will be notified should there be any changes to the use of restrictive practice, including updates to Risk Management Plans.
5	The centre manager and regional manager must satisfy themselves that they are aware of all risks pertaining to the centre. They must also ensure that risk assessments address risks specific to the centre and not just generic risks.	Statement of Purpose risk register has been updated to reflect specific risks to the centre. Revised statement of purpose risk register has also been review through team meeting on 14th July 2021.	All Risk Management documents to contain specific risk to the center. Center manager and Regional Manager to review risks, and relevant documents highlighting risk, on an ongoing basis to ensure that risks are center specific.
6	The regional manager must ensure there is a system in place for exit interviews to be completed with staff members and that these are used to inform learning and development	HR dept. oversee the system to ensure that all staff members who leave are offered the opportunity to complete an exit interviews	HR dept. keep central records of interviews offered and conducted and outline any learnings from the interviews. Regional Manager will ensure completion or attempts through monthly HR meetings

	within the centre and organisation.		and review of leavers. Regional Manager will ensure any learnings from exit interviews inform centre learning where appropriate.
	The regional manager must ensure that any risk assessment in relation to a reduction of staffing must include an assessment of the risks posed to the care of the young people.	Appropriate risk assessments will be conducted at any point in which staffing will be reduced. Risk assessments to focus on the care of young people. These will be completed in conjunction with Social Workers and Guardian ad Litems.	Appropriate risk assessments will be conducted at any point in which staffing will be reduced. Risk assessments to focus on the care of young people. These will be completed in conjunction with Social Workers and Guardian ad Litems.
	The regional manager and centre manager must ensure any changes to staffing are made in a consultative manner with social workers and also must ensure that staffing arrangements reflect the agreed staffing allocation as agreed and funded by the national private placement team.	Any future changes to staffing arrangements will be discussed in a consultative manner. Risk assessments in connection to reducing staff will be completed in conjunction with placing Social Workers and Guardian ad Litems through a professionals meeting.	The Private Placement team to be notified in the reduction of staff. Social Workers and Guardian ad Litems will be consulted prior to any changes being made to staffing levels.
	The regional manager should review the provision of the physical elements of training programmes and plan for this	Physical training has been reinstated in line with policy.	Physical training has been reinstated and will be carried out in line with policy.

	training to be carried out in a safe manner moving forward. The regional manager must ensure all training is carried out in line with the organisations induction policy.	The physical training aspect of induction has been reinstated in line with policy.	Training to be carried out in line with the organisational induction policy on an ongoing basis.