An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 074

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Good Sheperd Services**
Registered Capacity:	**Four young girls aged 16 -17** **Two young women aged 18+**
Type of Inspection:	**Announced**
Date of inspection:	**10th, 11th & 12th May 2021**
Registration Status:	**Registered from 3rd December 2019 to 3rd December 2022**
Inspection Team:	**Joanne Cogley** **Paschal McMahon**
Date Report Issued:	**19th October 2021**

Contents

1. Information about the inspection **4**

1.1 Centre Description
1.2 Methodology

2. Findings with regard to registration matters **8**

3. Inspection Findings **9**

3.1 Theme 5: Leadership, Governance and Management
3.2 Theme 6: Responsive Workforce

4. Corrective and Preventative Actions **20**

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 December 2003. At the time of this inspection the centre was in its fifth registration and was in year two of the cycle. The centre was registered without attached conditions from 3rd December 2019 to the 3rd December 2022.

The centre's purpose and function was to provide emergency, short to medium term accommodation for young females who were out of home or were at risk of homelessness. The centre offered six residential placements, two of which were specifically for 18 to 19 year old young women and were allocated on a planned basis. The other four placements were allocated to young girls aged 16 to 17 years and could be accessed in a planned or emergency basis. The centre in an emergency situation will offer a placement for 15 year olds as placement under a place of safety order, offering a place of safety until the next working day or to a maximum of three nights if the admission occurred on a Friday evening. The centre's model of care was described as solution focused brief therapy. This method of intervention focused on the young person's present and future circumstances and goals, rather than past experiences. It targeted the young person's default solution patterns and replaced them with problem solving approaches. There were four young people under the age of 18 in residence at the time of inspection.

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

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 5th July 2021 and to the relevant social work departments on the 5th 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 15th July 2021.

During the inspection process, inspectors found that staffing levels were beneath the regulatory requirements set out in the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III Article 7: Staffing. The Alternative Care Inspection and Monitoring Service wrote to the registered provider on 11/08/21 proposing to attach a condition to the registration of the centre until action had been taken to address staffing deficits. Representations were then received from the registered provider that contained further information and on review of this it was determined that the centre now meets regulatory requirements. The proposal to attach a condition to the registration of the centre was withdrawn on 15/10/21.

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: 074 without attached conditions from the 03rd December 2019 to the 03rd December 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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.

Inspectors found that the centre was operating in compliance with the required legislation and standards. From a review of the organisations suite of policies inspectors found that they required updating in line with the National Standards for Children's Residential Centres (HIQA) 2018. A number of policies had not been updated since 2017. While the CEO informed inspectors that the board of management intended to review all policies in 2021, inspectors found that there was no formal process for reviewing policies and procedures. The CEO must ensure that there is a formal process in place for reviewing the centre's policies and procedures and that all policies and procedures are updated in line with the National Standards in an appropriate timeframe. The centre manager must ensure when all policies are updated that appropriate training is provided to staff in relation to these. The centre had a child safeguarding statement in place accompanied by a letter of compliance from the child safeguarding compliance unit. The centre's child protection policies were reviewed and updated in October 2020 and staff members interviewed were aware of procedures relating to child protection and safeguarding.

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 leadership was evident throughout the centre and that there was a culture of learning. This was demonstrated through team meeting records, managers review of incidents and confirmed by staff members in interview. There was a clear organisational management structure consisting of a board of management, CEO, centre manager, deputy manager and three social care leaders. Through interview it was evident all were aware of their roles and responsibilities and knew the lines of

authority throughout the organisation. The CEO confirmed to inspectors they had service level agreements in place with the HSE and local Tusla managers and regular meetings occurred with these stakeholders to review the provision of service.
As previously mentioned under standard 5.1 a number of the centre's policies and procedures required updating in line with the national standards and guidelines.

The centre accepted emergency admissions on a 24/7 basis together with planned admissions. As part of the admission process the centre manager, in collaboration with the allocated social worker, would complete a pre-admission risk assessment. This risk assessment identified areas of vulnerabilities and allocated a risk rating of low, medium or high. Inspectors found that outside of these risk assessments there was no written evidence to demonstrate identification and management of risk on or during the young people's placement. From a review of care files inspectors found that in instances of young people exhibiting high risk behaviours, while key working and SEN reports were completed there were no risk management plans developed to manage and minimize these risks. Inspectors spoke with the allocated social workers for young people in placement and all stated that they were satisfied risk was managed appropriately within the centre. They stated any areas of risk would be discussed verbally between themselves and the centre manager on a daily or weekly basis. The centre manager must ensure risk assessments and risk management strategies are documented and evidenced on care files. The centre had a risk management framework that was developed in 2019. It was evident through interviews and questionnaires that staff members were not familiar with the policy and risk management framework and the centre manager must ensure training is completed with the staff team in relation to risk management.

Inspectors spoke with the centre manager in relation to the recent COVID-19 pandemic and found evidence that a number of control measures were put in place by the organisation in response to the pandemic. A review of Covid-19 policies, contingency plans and staff guidance documents evidenced effective and robust implementation of government guidelines, public health guidance and appropriate guidance and support for staff in their work. Inspectors spoke with the allocated social workers and they felt the centre had managed the recent Covid restrictions to a satisfactory level. Staff members confirmed that they continued to have adequate and on-going access to supplies of infection control products and equipment. Despite procedures in place, the centre manager informed inspectors that the centre had to shut down for a period of three days due to a Covid-19 outbreak within the centre. All social workers were informed of same and contingency arrangements were in place for the young people placed in the centre at the time of the outbreak.

There was an internal management structure evident within the centre however inspectors did not deem this appropriate to the size, purpose and function of the centre. The internal management structure consisted of a centre manager, deputy manager and three social care leaders. Inspectors were informed by staff during interviews that at times the manager took time off during the week in order to cover shifts every third weekend. The deputy manager worked 21 hours in the office and 18 hours shift work per week, one social care leader worked 30 hours a week, one social care leader worked 35 hours a week and the other social care leader worked full time. When the centre manager took annual leave there was no formal alternative management arrangements in place. The deputy manager would continue to work their standard hours in line with the rota and would be expected to take phone calls on the days they were not on shift when the centre manager was absent. Social workers stated that when the centre manager was on leave they did not have any issues communicating with the centre and always spoke with keyworkers for their young people to receive updates. The inspectors found that the difficulties for management arrangements stemmed from the difficulties of back-filling social care worker posts and this will be discussed further in this report under Standard 6.1. The CEO must ensure there are alternative management arrangements in place when the centre manager is absent.

The centre manager had introduced tasks lists that encompassed staff responsibilities. Each staff member had allocated tasks to complete and report back to management on a weekly basis. It was the expectation that the deputy manager would complete the managers tasks during times of leave.

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

The centre had a statement of purpose that clearly described the model of care together with the aims and objectives of the centre, the range of services available, the arrangements for the wellbeing and safety of children within the centre and the numbers of management and staff employed in the centre. The statement of purpose reflected the day-to-day operation of the centre. Inspectors found that it was clearly understood by staff members and its vision and ethos implemented on a day-to-day basis. The statement of purpose was last reviewed in November 2019 and was to be reviewed every two years. Information about the centre was also detailed in young people's booklets and parent's booklets.

The statement of purpose clearly outlined the centre's model of care and staff members both in interview and through their questionnaires demonstrated a clear understanding of the model of care. Staff members had received training in the centre's model of care with regular refresher training being provided.

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 had a complaints policy in place however inspectors found that this was not congruent with the Tusla 'Tell Us' policy and must be updated to reflect same. The policy stated that all complaints would be sent to the young persons social worker. Inspectors found that while complaints were being recorded, monitored and acted upon, the policy was not followed in relation to sharing all complaints with social workers. The CEO must ensure the complaints policy is reviewed to be congruent with Tusla "Tell Us" policy and also that the policy reflects practice in the centre. Inspectors met with a young person available during inspection and they confirmed they were aware of the complaints procedure and felt it was used effectively within the centre. They were satisfied that any issues they raised were dealt with promptly and they were satisfied with the outcomes and communication in relation to same.

Inspectors reviewed care files and supervision files and saw evidence of the CEO monitoring the files. There were notes recorded in relation to areas that required actions. These notes were a quantitative analysis as opposed to a qualitative analysis. The CEO must ensure that they develop and implement a governance tool to ensure that there is ongoing monitoring and assessment of the safety and quality of care being provided in the centre. This audit tool must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA). The CEO must also ensure they are working towards an annual review of compliance in relation to the centre's objectives completed as none had been completed at the time of inspection.

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

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

Actions required

- The CEO must ensure that there is a formal process in place for reviewing the centre's policies and procedures and that all policies and procedures are updated in line with the National Standards in an appropriate timeframe.
- The centre manager must ensure when all policies are updated that appropriate training is provided to staff in relation to these.
- The centre manager must ensure risk assessments are developed, documented and evidenced on care files.
- The centre manager must ensure training is completed with the staff team in relation to risk management.
- The CEO must ensure there are alternative management arrangements in place when the centre manager is absent.
- The CEO must ensure the complaints policy is reviewed to be congruent with Tusla "Tell Us" and also that the policy reflects practise in the centre.
- The CEO must ensure that they develop and implement a governance tool to ensure that there is ongoing monitoring and assessment of the safety and quality of care being provided in the centre. This audit tool must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The CEO must ensure they are working towards an annual review of compliance in relation to the centre's objectives completed.

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 saw evidence of workforce planning being undertaken. The centre's rosters were completed until September 2021 taking into account annual leave, retirements and planned leave. Inspectors did not find adequate workforce planning for replacement of staff through promotions or retirements and this should be reviewed by the CEO as a matter of priority. Inspectors were informed that there were ongoing discussions and negotiations with local Tusla managers in order to obtain funding to implement the staffing required.

The centre cared for four young girls aged 16 & 17 years and two young adults aged 18+ at any one time. The centre operated with two staff on duty at all times. The staffing consisted of a manager, deputy manager, three social care leaders and three social care workers however not all staff members worked full time. The deputy manager only worked part time shift work. Between the other six staff members they worked the equivalent of five full time staff members. The centre manager had been promoted in 2019 and the deputy manager had been promoted in 2020, neither of their posts had been back filled. Inspectors found the centre required a further three full time staff members in order to meet the alternative care inspection staffing requirements and to have sufficient numbers of staffing within the centre. The centre manager noted due to the shortfall the rotas were not working time compliant. Staff members interviewed did not feel the centre had adequate staffing but did note they felt this did not impact on the functioning of the rota and double cover was maintained at all times.

Inspectors met with a young person in placement who was present on the day of inspection and spoke in detail about staffing. The young person felt staffing was adequate and communicated to the inspectors that they felt it fitted into the centre's purpose and function to allow the girls to live independently. They felt more staff would lead to an over-reliance by the young people. They noted on all occasions when they required staff assistance they were available. They also noted that their keyworker was available to them the majority of the time and noted the longevity of the staff team which aided them to build better trusting relationships. This was

echoed by all social workers for young people living in the centre. Social workers stated when they contacted the centres, staff in the centre were accessible and they were always facilitated to speak with a manager or a keyworker. They also found communication exceptional within the team with all staff members aware of what was going on for young people.

Following the onsite inspection the centre manager confirmed a meeting had occurred with local Tusla managers and funding for additional staffing had been approved in principle. It was hoped funding would be processed within the coming weeks to ensure adequate staffing could be provided in the centre.

The staff working in the centre had an average length of service of seventeen years. Staff members length of service varied from six years to twenty-two years. All were qualified and had the necessary experience and competencies to meet the needs of the young people. The centre maintained a small relief panel to cover shortfalls in shifts and periods of planned leave. This panel consisted of five people and all were qualified in social care. During interviews staff members stated it was the culture of support and respect within the centre that kept them there.

The organisation had a formal procedure for on call which consisted of the CEO, the mission leader and five centre managers rotating an on call rota within the organisation. This involved being on call out of hours Monday to Sunday thus meaning each person completed on call on average once every seven weeks.

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

The organisation had policies and procedures in place for the recruitment and retention of staff members in line with legislation and best practice. Management and staff interviewed demonstrated an effective awareness of recruitment procedures. Inspectors found staff recruited had the necessary qualifications and personal attributes for their roles.

Inspectors found the centre manager had appropriate qualifications and experience to manage the centre. It was evident through a review of questionnaires, staff interviews and social work interviews that the centre manager was held in high regard and provided good support to staff and young people. Social workers interviewed as part of the process confirmed that the centre was well managed and

there was effective communication to ensure the needs of the young people were met. Through interview with staff members, they confirmed they had received a written job description and contract upon commencement of employment or change of roles. These documents were also available on staff personnel files. Inspectors found the centre had a written code of ethics and code of behaviour and the staff members interviewed were aware of this policy and its contents in relation to lone working and professional boundaries in work.

Inspectors were informed that each staff member had an individual personnel file and this was confirmed following a review of a sample of staff personnel files. Inspectors found from the sample of files reviewed that files were up to date with the exception of one staff file. In this instance garda vetting was dated from 2017 and had not been renewed since. The centre manager demonstrated an awareness of this oversight and inspectors were informed that renewed vetting had been applied for. Inspectors reviewed the centre's policies and did not find reference to vetting renewal timeframes and requirements. The centre's policies and procedures must ensure there is a formal process detailed for the renewal of garda vetting.

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 inspectors found that staff were aware of and understood their roles and responsibilities within the centre. In interviews staff demonstrated an awareness of the policies and procedures that were in place. There was evidence through interview with staff and social workers that staff were supported by management to effectively exercise their professional judgement in order to provide safe and effective care and they provided clear evidence of this in interviews. The centre had a number of procedures in place to protect staff members and minimise the risk to their safety. This included policies such as lone working, code of ethics, code of behaviour, staff safety and training. All interviewed also believed the length of experience and longevity of staff members added to staff safety.

Inspectors reviewed management meetings and team meetings, both of which occurred on a regular basis. Records of attendance were documented however attendance was not mandatory. Overall there was a good level of attendance. Where staff couldn't attend, they confirmed they were expected to read the minutes of all meetings when they were next on shift. Social workers interviewed noted that communication was exceptional within the team with all staff members aware of

what was going on for young people. From a review of team meeting minutes it was evident to inspectors that there was a good sense of team dynamics with a positive cohesive working group. There did not appear to be any set template or agenda for team meetings and the centre manager must ensure there is a more structured template around the recording of team meetings. There was evidence of a culture of learning and development through team meeting minutes.

Inspectors found the centre had a supervision policy which stated that all staff members would be supervised every two months. Inspectors found supervision for staff to be occurring within the stated timeframe and being carried out by the centre manager and deputy manager. Records were signed by both supervisor and supervisee and were held on file securely by the centre manager. Staff members had received a recognised model of effective supervision training. The centre manager confirmed they met with the CEO on a monthly basis to discuss operational aspects. They also met with an external supervisor on a monthly basis for professional development. Meetings between the CEO and centre manager were not recorded and the CEO must ensure moving forward that supervision records are evident to allow for transparency and accountability.

Inspectors did not find a system for staff appraisals in place. The centre manager must ensure a formal system is implemented in the policies and procedures so that each individual staff member's performance is formally appraised. There was a system in place to formally appraise the centre managers performance on an annual basis. A written record was kept of this appraisal and signed by the centre manager and CEO.

The centre had a system in place for supporting staff members to manage the impact of working in the centre. Staff had access to an employee assistance programme should the require it. Staff in interview and questionnaires also stated the level of support from the centre manager and CEO was to an exceptionally high level.

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

The organisation had a training and development policy in place to support staff to receive appropriate training and development. Inspectors noted this policy did not outline the mandatory training required to be completed by staff members and the CEO must ensure this is reviewed to include same. While it was evident through interview with the CEO that they were fully aware of the training needs of the staff

team, there was no formal process in place to complete a training needs analysis annually to inform the training calendar for the year ahead. Staff members noted they did not have access to the yearly training calendar and relied on the centre manager to inform them of upcoming training. Inspectors recommend this calendar is shared with all staff members.

Mandatory training was provided to permanent staff for example first aid, fire safety, behaviour management and children's first. Inspectors found that 'Covid-19' staff members were in place to cover any shortfall in staffing due to covid outbreaks. These staff members had only completed children's first eLearning training and had not completed any other training. The centre manager must ensure all staff members, regardless of status, complete all mandatory training. Staff members were encouraged to identify and source additional training to benefit their own professional development.

The centre had a written induction policy. The inspectors found that the induction policy was implemented in practice. All induction records, training records and continuous professional development records were maintained on staff personnel files.

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

Compliance with standards	
Practices met the required standard	**Standard 6.2**
Practices met the required standard in some respects only	**Standard 6.3** **Standard 6.4**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The CEO must ensure there is adequate workforce planning for replacement of staff through promotions or retirements.
- The CEO must ensure that the centres policies and procedures ensure they include a formal process detailed for the renewal of garda vetting.
- The centre manager must ensure there is a more structured template around the recording of team meetings.

- The CEO must ensure that supervision records with the centre manager are evident to allow for transparency and accountability.
- The centre manager must ensure a formal system is implemented in the policies and procedures so that each individual staff member's performance is formally appraised.
- The centre manager must ensure all staff members, regardless of status, complete all mandatory training.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The CEO must ensure that there is a formal process in place for reviewing the centre's policies and procedures and that all policies and procedures are updated in line with the National Standards in an appropriate timeframe.	The CEO/Management Team will develop a policy for approval by the GSC Board of Trustees outlining our formal process for developing and reviewing policies and procedures. Due for completion on 20.08.2021	This Policy will be reviewed every three years. The CEO will ensure compliance through the annual audit process.
	The centre manager must ensure when all policies are updated that appropriate training is provided to staff in relation to these.	The centre Policies and Procedures are currently being updated in line with the National Standards. Due to be completed by 17.09.2021	The centre Policies and Procedure will be reviewed every three years to ensure compliance unless there is a legislative or regulatory requirement to review it more frequently.
	The centre manager must ensure risk assessments are developed, documented and evidenced on care files.	A team day is planned for Monday 04.10.2021 to facilitate training following the update of our Policies and Procedures.	Once staff are trained forums such as staff meetings, supervision, handovers, personal development plans and team days will ensure ongoing knowledge and compliance in relation to these policies.

	The centre manager must ensure training is completed with the staff team in relation to risk management.	Training for the Manager and Deputy Manager has been arranged in relation to the development of risk assessments with Tusla Regional Manager for Quality Risk Service Improvement. Training arranged for 14.09.2021. A following up session will be held 4-6 weeks later to facilitate any issues regarding implementation. Training will be provided for the staff team on 28.09.2021 and 05.10.2021 with Tusla Regional Manager for Quality Risk Service Improvement.	Once the processes are in place with management trained appropriately ongoing audits by the manager and quarterly audits by the CEO will commence. The centre Manager and CEO will ensure compliance through monthly and quarterly audit processes.
	The CEO must ensure there are alternative management arrangements in place when the centre manager is absent.	If the Deputy Manager is unavailable to cover due to only being a half post an additional Social Care Leader will provide alternative management cover. This arrangement will commence 02.08.2021.	When leave is applied for by the manager the CEO will ensure that adequate alternative management cover is scheduled for that leave period.
	The CEO must ensure the complaints policy is reviewed to be congruent with	Our Complaints and Feedback policy is currently being updated in line with Tusla	Once the policy is approved by the Board it will reviewed in line with our new Policy

	Tusla "Tell Us" and also that the policy reflects practise in the centre.	Tell Us and is due to be presented to the Board of Trustees for approval at the next board meeting (scheduled for late July).	setting out our Policy development and review processes.
	The CEO must ensure that they develop and implement a governance tool to ensure that there is ongoing monitoring and assessment of the safety and quality of care being provided in the centre. This audit tool must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA).	The CEO and Manager will complete Tusla Quality Improvement Framework including the three principles of Child Centred, Well Led and Safe by 17.09.2021. The CEO and Centre Manager will also complete an audit tool that is bench marked against the National Standards for Children's Residential Centre, 2018 (HIQA). This audit will occur over a 10 week period (similar to Tusla Children's Residential Centres) with a 2 week period for reflection and review. This will occur from September to November 2021.	The CEO and Manager will review this Quality Improvement Framework every February going forward. It will also be informed by staff Personal Development Plans, our audit tool that is completed twice yearly and bench marked against the National Standards for Children's Residential Centres, 2018 (2018) and our Training Needs Analysis. The 10 week audit tool will be completed twice yearly going forward from Feb-April and Sept-Nov.
	The CEO must ensure they are working towards an annual review of compliance in relation to the centre's objectives completed.	The CEO and Manager will complete an annual review of the centres objectives in February 2022 based on the year 2021.	Thereafter the CEO and Manager will review on an annual basis every February the Centre Objectives achieved. This review will be informed but not exclusively so by the Tusla Quality Improvement

			Framework, our training need analysis and our audit tool that is completed twice yearly and bench marked against the national standards.
6	The CEO must ensure there is adequate workforce planning for replacement of staff through promotions or retirements.	The CEO and Manager will recruit the necessary permanent staff require to meet the regulations and HIQA National Standards once funding has been confirmed from Tusla Children's Residential. This request has been escalated to Tusla National Management Team and we are currently awaiting confirmation of funding.	Once the funding is confirmed the requirement process will begin and adequate staffing will be in place.
	The CEO must ensure that the centres policies and procedures ensure they include a formal process detailed for the renewal of garda vetting.	The current recruitment and selection policy will be edited to include the requirement for garda vetting to be renewed every three years.	Once the policy is approved by the Board it will reviewed in line with our new Policy on developing and reviewing policies.
	The centre manager must ensure there is a more structured template around the recording of team meetings.	The centre manager will develop a more structured framework to record the monthly staff meetings. Will begin in	Once devised and implemented the CEO will review its satisfactory use as part of her quarterly audit.

		August 2021	
	The CEO must ensure that supervision records with the centre manager are evident to allow for transparency and accountability.	A specific tailored supervision record has been devised to record the monthly meetings between the CEO and Manager. This process has already begun.	The CEO and Manager will continue to document monthly supervision meetings to allow for full transparency.
	The centre manager must ensure a formal system is implemented in the policies and procedures so that each individual staff member's performance is formally appraised.	A new Personal Development Plan has been developed by the centre Manager and will be utilised with all staff members as per the existing Policy on Training and Development.	The CEO and Manager will audit the compliance and satisfactory documented use of staff appraisals during our yearly self-assessment in February each year.
	The centre manager must ensure all staff members, regardless of status, complete all mandatory training.	The centre manager will ensure that all new hires regardless of status complete mandatory training. Due to Covid 19 restrictions a number of trainings were postponed or not available on public health advice. All current staff regardless of status will have completed all mandatory training by late September 2021.	The Centre Manager and CEO will complete an annual training needs analysis incorporating both mandatory and non-mandatory training. This will take place in February each year. The Personal Development Plans and Tusla Quality Improvement Framework will help inform this process.