Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 163

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Tus Nua Childcare Services**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Unannounced**
Date of inspection:	**4th, 5th and 6th March 2024**
Registration Status:	**Registered from the 24th of October 2022 to the 24th October 2025**
Inspection Team:	**Ciara Nangle** **Lorna Wogan**
Date Report Issued:	**24th July 2024**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in October 2019. At the time of this inspection the centre was in its second registration and was in year two of the cycle. The centre was registered without attached conditions from 24th October 2022 to the 24th October 2025.

The centre was registered as a multi occupancy centre to provide medium to long term care for up to four young people from age thirteen to seventeen on admission. The model of care was described as the secure base model which was informed by attachment theory and resilience. There were three young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.3

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, centre manager and to the relevant social work departments on the 23rd May 2024. 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 Registered Provider returned the CAPA on the 11th June 2024 and this was deemed to be unsatisfactory. A second CAPA was returned to the ACIMS on the 26th June 2024. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan were used to determine the centre's compliance and adherence to the 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: 163 without attached conditions from the 24th October 2022 to the 24th October 2025.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

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.

The organisation had policies and procedures in place that were aligned to Children's First and other relevant legislation. The organisation's suite of policies and procedures had been reviewed in 2023. The child protection policy was a standalone policy and was reviewed in line with requirements. The child protection policy set out the procedures to identify and report child protection concerns and identified the key roles in safeguarding such as the mandated person, relevant person and designated liaison person for the centre. Additionally, the policy outlined the response pathway should a young person make an allegation of abuse against a member of the team to safeguard both the young person and the staff member. The organisation also had safeguarding policies and procedures in place for the staff including, but not limited to safe recruitment procedures, lone working, and a staff code of conduct.

Inspectors saw evidence of policies and procedures being discussed as part of the induction process for staff into the centre, however centre records did not demonstrate that policies and procedures were regularly reviewed with the team during team meetings or during individual supervisions. While staff had undertaken child protection training which included training in the centre's child protection policies and procedures, in interview staff did not demonstrate good working knowledge of these policies in practice. Within a sample of documents reviewed as part of this inspection, inspectors found incidents where safeguarding policies were not followed, e.g. recruitment and this was not identified by managers or members of the team.

There was a child safeguarding statement in place in the centre which included a risk assessment of the identified relevant risks of harm/abuse as defined under Children's First Act 2015 and the controls in place to mitigate against these risks. There was a procedure in place for maintaining a list of mandated persons in the centre as required under the Children's First Act, 2015. Staff in interview could outline the steps to be taken should an allegation of abuse be disclosed to them and understood

that they had a responsibility to report this and the procedure to do this. However, they did not link this process to their responsibility as a mandated person.

A child protection register was maintained within the centre for all reported child protection and welfare referrals (CPWRFs). From a sample reviewed these were reported appropriately in line with Children's First and were reported in a timely manner. There was follow up from the centre in relation to the status of these referrals. When the social work department closed these, the correspondence was maintained on the file alongside the referral form.

There was a system in place to maintain a record of all visitors to the centre however the inspectors found the record book was damaged and not maintained in a systematic or secure manner thus was not an effective safeguarding measure.

The centre had a database in place to track mandatory and any relevant supplementary training completed by the team. This included the dates of completion for Children's First, child protection, behaviour management training and other mandatory training. This training database was shared with the advisory committee, who's role was to support the effective operation of the centre. This database allowed the advisory committee to have oversight of and monitor the completion of mandatory training by staff working within the centre to support safe care. However, inspectors found that the dates recorded within the training database were not up to date. Inspectors found that all staff had completed Children's First training however this was not recorded within the database. Additionally, the inspectors found that staff files did evidence that all staff had completed the required mandatory training.

Tusla's Mandated Persons training was not completed by all team members however a recent compliance audit identified this and there was an action plan to ensure all staff completed this training and Tusla's training on child sexual exploitation. The registered provider must provide evidence to the inspectorate that all staff have completed the required child safeguarding training and that the training database is up to date and aligned to the training undertaken by staff.

There was a policy in place in relation to protected disclosures. Staff interviewed were aware of the reporting structure within the service however they were not able to describe the circumstances where this policy might apply and its safeguarding function. The register provider must also ensure that external agencies to whom staff may make a protected disclosure to are identified within the protected disclosure policy.

The centre had an anti-bullying policy in place. In the months prior to this inspection the dynamic between the young people within the centre had been a concern. The centre responded appropriately in relation to this, convened strategy meetings and reported the concerns through the appropriate mechanisms. Individual work was completed with the young people in relation to this and safeguards for all young people were implemented. This had a positive impact on the dynamics between the young people in the centre, and while at times their collaborative behaviour was at times challenging, at the time of inspection this was not assessed to be bullying in nature.

There was evidence that the centre staff worked in a collaborative manner with the social workers and other external professionals. The centre manager advocated for strategy meetings when they identified a risk and ensured these were convened in a timely manner. There was evidence of good levels of communication with the young people's families and a parent interviewed by the inspectors reported they had positive interactions with the team members and were happy with the care their child received. The social workers interviewed as part of this inspection advised they were satisfied that they were notified of significant events in a timely manner, and they were provided with updated information about the young people. The social workers were satisfied the young people's needs were being met in the centre at this time. Parent's and guardians were kept up to date by the centre, however at times the social workers would assume this responsibility. This was dependant on the young person and their individual needs.

Areas of individual vulnerability were identified and recorded on each young person's file on a risk register. There was evidence on file that the individual risk assessments were developed to protect the young people from harm. Individual risk assessments on file were completed in line with the centre's risk management framework; the risk was measured; the level of risk identified and they included the measures put in place to minimise the risk. There was evidence of monthly reviews of the risk assessments however the review systems required improvements to evidence additional controls in place to reduce individual risks, to evidence the rationale for closing risk assessments and the communication of identified changes on the risk assessments to team members.

While individual work was completed with the young people, inspectors found from a review of their placement plans and individual work there was limited work completed with the young people specifically in relation to their identified

vulnerabilities and risks. Within handover meetings daily topics for individual work were identified however it was difficult to ascertain how these were tracked to completion as there was no corresponding key working plans in place for the young people. Additionally, in some instances the goals set out in the placement plans were overarching as opposed to the identification of specific achievable goals.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that all staff are familiar with and competent in their application of the centre's policies and procedures.
- The registered provider must ensure that the training database is kept up to date and that all certificates of completed training are maintained on personnel files.
- The register provider must ensure that all staff maintain up to date training the centre's mandatory training as set out in their policy and procedures.
- The registered provider must ensure that placement plans contain specific and achievable goals for the month and key working plans are in place to support the young people addressing identified areas of need and vulnerability.
- The register provider must ensure that the young people's risk register clearly indicates outcomes of reviews and rationale for closure of risk assessments and there is a clear mechanism in place to share this information with the team.
- The register provider must ensure staff are familiar with the purpose of the protected disclosure policy and outline in the policy the external agencies to whom staff can report a concern.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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

The registered provider had recently appointed an advisory committee. The scope of this committee was to provide oversight, governance, advice and support and to contribute to the effective operation of the centre. Based on the information provided, through a manager's report and verbal feedback from the centre manager who is also the CEO, the committee aimed to identify patterns, trends, risks and area for development within the organisation. The report prepared by the centre manager provided an update in relation to the young people in the centre, including an overview of significant event notifications (SENs), child protection and welfare referrals, complaints and other care issues arising. Centre compliance audits were also reviewed by the committee, and they had oversight of the implementation of the action plans developed to address deficits identified. The committee also considered staff issues, including recruitment. The committee was in place since July 2023, and they met monthly. Brief minutes were maintained from these meetings and actions agreed were included.

Significant incidents in the centre were reviewed through monthly Significant Event Review Group (SERG) meetings which were chaired by an external professional. The meetings reviewed the SENs which had occurred in the preceding month. The chair of the SERG meeting provided an analysis of presenting behaviours and provided team members with additional insights into the young people's behaviour. However, there was no evidence that these meetings reviewed staff interventions, or whether incidents were managed in line with the young person's individual behaviour support plan. Additionally, there was no evidence of an analysis of patterns or trends arising from incidents or that learning outcomes or actions were identified to promote improvements in the management of behaviour that challenged.

Fortnightly team meetings were undertaken, and attendance was mandatory. Records from these meetings indicated that extensive discussions occurred in relation to the young people's care with a focus on placement plans and goals. However, team meeting records did not evidence that other key aspects of the care

practices were discussed and reviewed by the managers and team for example child protection concerns, complaints, risk assessments, audits or teamwork.

Previously, there was an external clinical psychologist appointed to oversee the development of the placement plans for the young people, This external oversight of placement planning had supported the improvement of care provided within the centre. The person appointed in this role left their post in the summer of 2023 and another clinician was appointed for a short period of time from Sept-Dec 2023. At the time of inspection, the post was vacant however, the registered provider had identified a professional to take on this role in the coming months.

While there was a variety of forums in place to review the quality, safety, and continuity of care within the centre the inspectors found there was a lack of congruence between the records from each of these forums and it was difficult to track how they were being used to inform care provision on a practical level. The discrepancies identified within the centre records evidenced deficits in the overall governance within the centre.

The registered provider had contracted an external service to complete themed audits aligned to the National Standards for Children's Residential Centres, 2018 (HIQA) on a scheduled basis. In the last six months of 2023, two themed audits were completed and an additional audit was undertaken to review the implementation of the action plans created from these audits. The outcome of these audits were discussed at the advisory committee meetings and updates provided in relation to the implementation of the action plans. An audit under Theme Six of the National Standards for Children's Residential Centres, 2018 (HIQA) was completed prior to this inspection and the centre were awaiting the audit report. There were two further themed audits scheduled for 2024. Staff interviewed were familiar with the audit process and informed inspectors that audits were discussed at team meetings.

The centre had a complaints policy that was reviewed in 2023 and maintained a complaints register. There were two complaints recorded on the complaints register within the preceding twelve months. Both of these complaints had been resolved. The inspectors found that one young person had expressed dissatisfaction in relation to their social worker however staff had not guided them to submit a complaint via Tell Us, Tusla's complaints procedure. Additionally, this compliant was not recorded on the centre's complaints register. There was evidence that the centre's complaints procedure and Tusla's Tell Us, were explained to the young people on their admission to the centre. However, there was no further evidence that the centre's complaints

procedure was further discussed with the young people. In discussion with the young people, they advised inspectors that they knew they could make a complaint if they wished, and they had heard of 'Tell Us' but weren't sure about it. The inspectors found that staff interviewed were not familiar with the centre's complaints procedure, how complaints were categorised, investigated, recorded, or reported. Additionally, staff interviewed were not aware how to process a complaint through Tell Us. Given there had only been two complaints recorded there had not been any analysis of trends or patterns completed in relation to these.

The centre had contacted Empowering People in Care (EPIC), an independent advocacy group for young people in care, to schedule a visit to the centre. EPIC had not visited any of the current residents within the centre to date, however there was information about the advocacy service available to the young people in the centre.

The registered provider had not completed an annual review of compliance since the centre commenced operations in 2019 as is required to ensure effective governance and compliance with standards. This was raised in previous inspections of this service and remains outstanding.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed as part of this inspection**
Practices met the required standard in some respects only	**Standard 5.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed as part of this inspection**

Actions required

- The registered provider must ensure that all staff are trained in the complaints policy and Tusla's Tell Us Policy and are competent in its implementation.
- The register provider must ensure that individual work is completed with the young people in relation to complaints; both the centre's policy and Tusla's

Tell Us policy, on a periodic basis to ensure they are aware how to make a complaint should they wish to.

- The registered provider must ensure that the various forums in place to review the quality, safety and continuity of care within the centre are aligned and learning from these forums is shared and applied in practice within the centre.
- The registered provider must undertake an annual review of compliance with the centre's objectives as per the National Standards for Children's Residential Centres, 2018 (HIQA)

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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.

At the time of inspection, the centre was operating with a staff team below the minimum requirement of the Alternative Care Inspection and Monitoring Service Regulatory Notice on Minimum Staffing Level, June 2023. However, two of the team had only left in the weeks preceding the inspection and recruitment was ongoing. The registered provider had attempted to provide consistency to the young people by utilising two consistent agency staff members whenever possible and both the centre manager and deputy were covering shifts where required. From a review of a sample of rosters, the centre was maintaining a level of consistency in the staff working in the centre despite the depleted staffing levels.

All staff in the centre had a job description on their file which was shared with them at the time of job offer. Staff in interview were aware of the expectations of their roles and the lines of accountability within the centre. However, as detailed above the interviews completed with staff and documentation reviewed did not demonstrate that staff were aware and confident in the application of the centre's policies and procedures. In one incident where inspectors identified that the relevant policies were not followed, inspectors did not see any evidence of follow up in relation to this with the individual staff member involved or the team to ensure that learning for this incident was shared. Improvement in relation to the development of practice in line

with policies and procedures with the team is required to ensure safe care for the young people.

There was no induction schedule on personnel files to indicate what was covered in the staff induction process. One of the social care leaders who had recently been appointed in the role, had not been recruited in line with the recruitment process and at the time of inspection had not received an induction into the role and there was no plan in place for this to be undertaken.

As part of their role, social care leaders were required to provide on-call support to the centre alongside the deputy and centre manager. Given they will be providing advice and support to the team members it is imperative that they are aware of and competent in the policies and procedures in place in the centre so that they can provide effective support to the care team if required.

The staff team was relatively new and did not have significant levels of experience. As such the centre management team was providing a high level of support throughout the day to the team in planning and caring for the young people. This was evident through managements involvement in SENs and was observed while inspectors were in the centre.

As previously outlined in the report within the SERG meetings there was an element of reflective practice to help the team to reflect and understand where the young people's behaviour was arising from. The registered provider planned for further work in this area to be undertaken in the coming months however this wasn't in place at the time of inspection and there was no clear plan around its development yet. Regular team meetings were occurring, and attendance was good however as discussed in the preceding section these did not have a focus on learning and development of the team.

Additionally, training was provided to the team when identified as required to meet the specific needs of the young people. The registered provider had already engaged a private provider who will provide the team with the required mandatory training.

There was a supervision policy in place and within the sample of supervision records reviewed supervision was occurring in line with the policy. Within the initial supervision the purpose and function of the supervision process was discussed. At the time of inspection supervision training was not provided to supervisees however the

centre manager informed the inspectors this training was to be scheduled in the coming months. Supervisors had completed the required supervision training.

Within the sample of supervisions records reviewed as part of this inspection, inspectors did not see evidence of review or feedback on staff's practice, areas for development, or reflective practices. The supervision records maintained were brief. Staff in interview reported they found supervision beneficial and supportive to them in their work.

Given that most of the team had been in post for less than one year they were not eligible for an annual evaluation of their performance in their role. The inspectors found that team members who were eligible had not received their annual performance appraisal. The centre manager must ensure that staff receive their annual performance review in line with the centre policy. Additionally, probation reviews had not occurred for the relevant members of the team and the centre manager confirmed that these remained outstanding at the time of inspection. Development within the area of staff evaluation and feedback on performance is required, both within annual/probation reviews and on an ongoing basis through supervision or other forums to support the development of best care practices within the centre.

There were no risks to the staff safety identified at the time of this inspection. Staff in interview spoke positively about their experience of working in the centre and the support they received from the centre management team. Staff had access to an employee assistance programme that provided additional external supports to staff where required.

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 under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that there are clear plans and structures in place to support the professional development of the team through reflective learning and training.
- The registered provider must ensure that staff's performance is formally appraised at least once a year in line with the National Standard's for Children's Residential Centre's, HIQA (2018).

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure that all staff are familiar with and competent in their application of the centre's policies and procedures.	The registered provider has engaged the services of an external consultant, and they are currently developing a practical day to day guide that will be delivered as a training piece for all new staff that join the service. This guide will be linked to the centre's policies and procedures and will aim to provide staff guidance on how our policies and procedures are being implemented in practical terms. This will be part of all new staff's induction and is in addition to our current induction that all staff read the centre's policies and procedures and sign to confirm they understand them. This training will be provided to all staff by 12.07.24	On call policy has been discussed with all staff and the procedure for contacting on call has been explained once more to further ensure there is no disruption to service delivery. External Audits take place every 8 weeks. Staff on shift will now be interviewed about centre policies as part of this audit with the expectation they can relate theory to practice and provide examples. Any deficits identified in this process with individual staff will be followed up as part of staff's supervision. If required PIP's will be implemented.
	The registered provider must ensure that the training database is kept up to date and that	The registered provider has employed the services of a part time administer with responsibility for ensuring our training database is kept up to date.	The training database is held within a HR system.

	all certificates of completed training are maintained on personnel files. The register provider must ensure that all staff maintain up to date training the centre's mandatory training as set out in their policy and procedures. The registered provider must ensure that placement plans contain specific and achievable goals for the month and key working plans are in place to support the young people addressing identified areas of need and vulnerability.	All training certificates will be held within a new HR system. This process has already commenced with existing training certificates already uploaded. The registered provider has changed the training service engaged that provides staff training. This service allows for individual staff to be trained and no longer relies on block bookings. The registered provider has completed work with the staff team in relation to placement planning for the young people. Key workers completing the young person's placements plans will ensure identified goals are realistic and achievable. Key working plans have been implemented and are used in consultation with the young people.	The advisory committee, commissioned external auditors and external inspectors will be able to access this system for the purpose of audit and inspection. The part time administrator takes responsibility for the arrangement and follow up on staff training. The advisory committee, commissioned external auditors and external inspectors will be able to access HR system for the purpose of audit and inspection. Key working plans and their progress will now be discussed at monthly team meetings with key workers taking the lead and ensuring the work is being completed.

	The register provider must ensure that the young people's risk register clearly indicates outcomes of reviews and rationale for closure of risk assessments and there is a clear mechanism in place to share this information with the team. The register provider must ensure staff are familiar with the purpose of the protected disclosure policy and outline in the policy the external agencies to whom staff can report a concern.	Risk register will be discussed at team meetings to update the staff team on any changes to risk ratings and this will also include risks that have been closed. The reason for closure will also be documented on the initial risk assessment. The register provider has discussed the protected disclosure policy will all staff at our team meeting on the 24.05.24. All staff are aware of the reporting protocol and to whom staff report a concern to.	The changes to the recording of the risk register will be review monthly by the centre management team and will be available to the advisory committee on a monthly basis and the external auditors. Protected disclosure policy is now identified separately on our training database as part of a staff's induction. This will be refreshed annually. Our HR system emails the individual staff, our administrator and centre manager on when a staff's training is due to expire to ensure there are no gaps in staff's training.
5	The registered provider must ensure that all staff are trained in the	The register provider has discussed the complaints policy with all staff in their team meeting on the	Staff are now expected to refresh themselves on centre's policy and procedures annually.

	centre's complaints policy and Tusla's Tell Us Policy and are competent in its implementation.	24.05.24 and directed staff to the complaints policy where Tusla's Tell Us policy is mentioned.	Our HR system emails the individual staff, our administrator and centre manager on when a staff's training is due to expire.
	The register provider must ensure that individual work is completed with the young people in relation to complaints; both the centre's policy and Tusla's Tell Us policy, on a periodic basis to ensure they are aware how to make a complaint should they wish to.	Individual key work was completed with the young people to remind them on their right to make a complaint and how to make a complaint. They were also informed about Tusla's Tell Us policy.	The centre manager will ensure the young people are reminded about how to make a complaint in their residents meeting every couple of months.
	The registered provider must ensure that the various forums in place to review the quality, safety and continuity of	The registered provider has engaged the services of a behaviour analyst to review the quality, safety and continuity of care within the centre through the monthly SERG meetings. This will ensure that	The registered provider attends the monthly SERG and reviews the SERG meeting minutes. These minutes are available for external auditors.

	care within the centre are aligned and learning from these forums is shared and applied in practice within the centre. The registered provider must undertake an annual review of compliance with the centre's objectives as per the National Standards for Children's Residential Centres, 2018 (HIQA)	reflection and learning for the team can be more easily reviewed and evidenced. The registered provider has engaged an external consultant to support the service in undertaking an annual review of compliance. This will be completed Aug 2024.	The annual review of compliance will be included in the external auditing process and will be available for inspection when completed.
6	The registered provider must ensure that there are clear plans and structures in place to support the professional development of the team through reflective learning and training.	The registered provider will implement an inhouse training day every six months to support staff development and to reflect on service delivery identifying strengths and weaknesses. To be start in September 2024 and take place every six months thereafter.	Registered provider will include this in house training day/staff development as part of our suite of training and will be included on our training database.

	The registered provider must ensure that staff's performance is formally appraised at least once a year in line with the National Standard's for Children's Residential Centre's, HIQA (2018).	The administrator will inform the centre manager and individual staff of when their appraisal is due for completion and the end of the staff probationary period and at the end of the employees first year. The management team will complete the staff appraisal with the individual employee.	This task of ensuring the appraisals are completed in a timely manner has now been assigned to the part time administrator.