An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 193

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Brighter Futures for Children**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced Themed Inspection**
Date of inspection:	**04th, 09th, and 11th November**
Registration Status:	**Registered from 17th May 2021 to 17th May 2024**
Inspection Team:	**Lorna Wogan** **Sinead Tierney**
Date Report Issued:	**22nd March 2022**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 17th of May 2021. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from 17th of May 2021 to the 17th May 2024. This was the first inspection of the centre since its registration.

The centre was registered to provide either single occupancy placements or multi-occupancy placements, for up to two young people, male and female, aged thirteen to seventeen years on admission. The centre's stated objectives were to provide a safe and structured residential environment with a high level of support in line with *The Three Pillars Model of Care (Three Pillars of Transforming Care, Bath and Seita, 2018)*. The model was based on three key elements safety, connections and coping. The therapeutic approach focused on emotional containment and positive reinforcement to assist young people to develop internal controls of behaviour and to promote resilience and responsibility. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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 and to the relevant social work departments on the 13th December 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the Alternative Care Inspection and Monitoring Service to ensure that any identified shortfalls were comprehensively addressed. The centre manager returned the report with a CAPA on the 27th December 2021. The CAPA returned was used to inform the registration decision.

The findings of this report and assessment of the submitted CAPA deem that the centre was not operating in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies, Article 7: Staffing and Article 6: Person in Charge.

As such it is the decision of the Child and Family Agency to register this centre, ID Number: 193 with an attached condition from the 17th of May 2021 to the 17th May 2024 pursuant to Part VIII, 1991 Child Care Act. The condition being:

- There will be no further admissions to the centre until such time that the centre is fully compliant with Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 5: *Care Practices and Operational Policies* and Article 7: *Staffing* and that appropriate and suitable care practices and operational policies are in place and that the staffing requirements in the centre are appropriate having regard to the number of children residing in the centre and the nature of their needs.

This condition will be attached to the registration of the centre from 07th March 2022 and will be reviewed on or before 05th September 2022.

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.

Overall, the inspectors found this standard was well met in relation to care planning and centre-based placement planning. While the inspectors found deficits in the governance and oversight structures which will be outlined later in the report the inspectors found that the care planning and placement planning processes were not compromised due to this issue. There was a good standard of report writing and a record management system that evidenced the planning processes, care practices, model of care and the interventions and outcomes for the young person in placement. There was evidence of robust planning for the young person's admission with an admission meeting and a pre-admission risk assessment undertaken that outlined strategies to respond to and manage identified risks.

The initial statutory review took place within the first two weeks of placement and an up-to-date care plan was on file. The care plan reviewed by the inspectors was comprehensive and detailed the aims and objectives of the placement. Specific tasks were assigned to relevant professionals. The social worker confirmed they were satisfied that the tasks assigned to the centre staff as part of the care planning process were being implemented. There was evidence on file of regular communication with the allocated social worker to keep progressing the goals of the care plan. There was evidence of regular planning and strategy meetings that took place outside of the statutory review process to progress the young person's care. The care plan reflected the young person's views and they participated in the statutory review meeting. The young person provided positive feedback to the statutory review about the staff working in the centre. Minutes of the statutory review meeting were on file and the centre also maintained their own records of all care planning meetings. Reports prepared by the key workers and submitted to the statutory reviews were held on the individual care file.

The young person had an up-to-date placement plan on file. The inspectors found that the goals of the placement plan were aligned to the statutory care plan. The placement plan was updated monthly or when significant changes were required.

There was evidence that goals such as education, the young person's voice, individual living skills, activities, aftercare, family contact, safety and mental wellbeing were identified on the placement plans. While the young person did not read the placement plan document there was evidence in key working sessions that the goals identified in the placement plan were discussed. Key working was mainly opportunity led and key working records were of a good standard. The key work records also reflected the young person's view on aspects of their life. There was evidence of oversight of key working by the registered proprietor and the acting centre manager. There was a key work schedule set out for each month and this was a live working document signed by staff when key working was completed or declined. While key working was of a good standard in the centre, inspectors recommend that the minutes of team meetings and the staff supervision records reflect the discussions on key working and placement planning.

The young person was facilitated and supported by staff to access specialist supports. There was evidence that staff were alert to the young person's mental health and wellbeing and took appropriate action to ensure there were appropriate services in place.

The social worker was satisfied with the level of communication with the centre staff. There was evidence that the social worker and the centre manager had open communication and were able to raise and discuss inter-agency and inter-disciplinary issues where they occurred. There was evidence of good collaboration between all the services involved in the young person's care. The social worker confirmed they received updated placement plans, significant event notifications and weekly progress reports. There was evidence of visits by the social worker to the young person in the centre in line with regulations and the social worker confirmed they had the opportunity to meet the young person in private when visiting. The social worker confirmed the young person had not raised any issue of concern or complaint about their care in the centre.

Compliance with Regulations	
Regulations met	Regulation 5
Regulations not met	None identified

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

Regulation 5: Care Practices 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.

Since the centre commenced operations there was no stable, consistent management team in place. The inspectors found that Regulation 6 (1) and (2) of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 in relation to the person in charge was not met. This finding was reached due to the overall lack of stable management in place since the centre opened and the failure of the registered proprietor to notify the statutory body of the changes in management.

An acting centre manager was appointed in October 2021 and there was evidence of clear and effective leadership since this date. The acting manager and deputy manager had worked hard to re-establish governance structures and ensure robust oversight of care practice. Staff supervision records reviewed by the inspectors evidenced this and staff remarked on the effective leadership now in place. However, due to inadequate staffing levels the managers had to work across the staff roster and this impacted on their capacity to complete their management duties within their designated working hours. The registered proprietor must resolve the staffing issues to allow for robust oversight and governance of the centre.

Staff interviewed by the inspectors understood their roles and responsibilities and had been provided with job descriptions and induction training. There were defined governance structures within the organisation however the level of governance and oversight of practice had been compromised and eroded following the resignation of the former centre manager, deputy manager and team leaders. The planned leave of the quality assurance officer also impacted on the external governance mechanisms. Staffing issues across the service impacted on the role of the registered provider who was managing another centre in the organisation since May 2021 and provided relief cover in both centres where staff shortfalls arose. As previously stated, the current managers were covering shifts on the roster which resulted in them working overtime to complete their management tasks. The on-going changes within the management team since the young person was admitted had led to some identified miscommunications, lack of coherent leadership and guidance for staff and blurred roles and responsibilities. The turnover of staff is not sustainable going forward and the registered provider must ensure that leadership roles at every level are filled within the centre and the management structure is stabilized going forward.

There was evidence the quality assurance officer had undertaken a remote audit of aspects of the centre's recording systems and had identified gaps and deficits in several of the centre's recording practices. It was not evident that the findings of this quality assurance audit were relayed to the staff team to promote learning and undertake action in relation to the findings. The current manager had recently received a copy of the audit and confirmed to the inspectors that they were reviewing the audit to ensure all the findings were addressed. At the time of the inspection there was no external systems in place to audit centre practices. The registered proprietor must ensure there are adequate systems in place for the external oversight of care practices in the centre and to assess the centre's compliance with the national standards.

The inspectors found there was oversight and robust gatekeeping in relation to the assessment of referrals to the centre by the registered proprietor. However, in relation to formal governance meetings, a senior management meeting process had only recently commenced. The registered proprietor confirmed management meetings would be scheduled on a fortnightly basis going forward. A record of three management meetings undertaken to date were reviewed by the inspectors. There was evidence of discussions in relation to staffing needs, recruitment of staff, risk management and a review of significant events that provided an element of shared learning across the two centres within the service. There was evidence that the management team had assessed that waking night staff was not required in the centre

however the inspectors recommend this is kept under review. Inspectors found that there were only four team meetings evidenced on file since August 2021 which was not in line with the policy of fortnightly team meetings. The team meeting records reviewed by the inspectors evidenced a culture of openness to address issues as they arose and of the team holding each other to account.

The registered proprietor had responsibility to provide formal supervision to the acting centre manager. There was regular daily contact between the centre manager and the registered proprietor, and the centre manager stated that the registered proprietor was accessible and supportive to them in their role. The inspectors found that formal supervision of the centre manager had not occurred since their appointment on 1st October 2021. Given their acting position, limited of experience working with children in residential care and in management alongside the extensive hours being worked, the centre manager must receive more regular formal supervision as a matter of priority.

The deputy manager was experienced and qualified. There was an internal management structure appropriate to the size and the purpose and function of the centre. However, at the time of the inspection there were not three team leaders in post as set out in the centre's statement of purpose. One of the team leaders had resigned from their post and was on extended leave up to the end of their notice period and another team leader was transferred to another centre which left only one team leader in post at the time of the inspection. This further eroded the internal mentoring and leadership support for staff working directly with the young person.

At the time of this inspection the registered provider had not applied for a contract with the funding body as there were insufficient staffing resources in place to meet the contracting requirements. The registered provider informed the inspectors that they hoped to apply for new contracts before the end of December 2021.

The centre manager was in an acting position as they did not meet the Tusla requirements to be appointed in this role due to in their qualification and experience working with children in residential care. The registered provider must ensure that the appointed centre manager has the required qualification and the required level of experience working with children in residential care.

An inspection in May 2021 of another service operated by the registered provider outlined the requirement of the service to update their suite of policies and procedures along with their child safeguarding policy in line with current legislation

and national standards. The inspectors found that the timeframe identified for the completion of this required action was not met. The registered provider stated they were unable to update the policies within the timeframe identified on the corrective action plan. The registered proprietor confirmed that the operational polices currently remained under review. The centre's child safeguarding policy was also being updated in line with the Children First Act, 2015 and Children First: National Guidance for the Protection and Welfare of Children, 2017. The inspectors found that Regulation 5 of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 in relation to the care practices and operational policies was not met at this time.

There was a risk framework and supporting structures in place in the centre for the identification, assessment and management of risk. The centre maintained individual risk assessments in the young person's care file, and they had a centre risk register for all other risks associated with the general operation of the centre. There was evidence of oversight of risks by the centre manager. There was evidence of on-line training undertaken by staff in risk assessment. Overall, the inspectors found there was good identification of the individual risks associated with the young person's behaviour and evidence of mitigation measures in place. Staff were alert to risk and were knowledgeable about the risks associated with the young person's presentation. While risk management was discussed at team meetings and the identification of risk was evident, the on-going monitoring and review of the effectiveness of their risk mitigation measures was not evident in the team meeting discussions. The records showed that individual risks were reviewed every three months. The registered provider must ensure there are more robust and frequent reviews of the individual risks associated with the young person's behaviour as outlined in the centre's risk management policy.

The inspectors found that Covid-19 policies and procedures were adhered to in the centre. The centre had protocols in place in relation to hand hygiene, cleaning schedules, sanitization, PPE, temperature checks and health screening of visitors. There was a staffing contingency plan developed by the quality assurance officer in event of a Covid-19 infection in centre. The centre manager confirmed to the inspectors that they would review the staffing contingency plan in terms of their capacity to implement it at this time due to shortfalls in staffing.

There was evidence that the centre manager and the deputy manager had a formal meeting to identify all the management duties and the record evidenced the

delegation of these specific management tasks between the centre manager and the deputy manager.

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

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

Actions Required:

- The registered provider must ensure that leadership roles at every level within the centre are filled and the management structure is stabilized going forward.
- The registered proprietor must ensure there are adequate systems in place for the external oversight of care practices in the centre and to assess the centre's compliance with the national standards while the quality assurance officer is on leave.
- The registered provider must ensure that the appointed centre manager has the required qualification and the required level of experience working with children in residential care.
- The registered provider must ensure that the governance systems in place are in compliance with the centres' policies. Senior management meetings, management meetings and team meetings must be carried out in line with centre policy.
- The registered proprietor must set out a clear timeframe for the review of all operational policies to ensure they meet the requirements of the national standards and the child safeguarding policy must also be updated in line with Children First, 2017.
- The registered provider must ensure there are more robust and frequent reviews of the individual risks associated with the young person's behaviour as outlined in the centre's risk management policy.

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.

The team comprised of an acting centre manager, deputy manager, one team leader, two social care staff and one relief staff. One of the team leaders on the staff team was transferred to another centre at the time of the inspection. The inspectors reviewed the staffing rosters and were assured that there were always two staff on duty as required. However, the inspectors found there were not adequate numbers of staff employed in the centre as required by the regulations, or in compliance with the current Tusla requirement on staffing numbers or in line with the centre's statement of purpose and registration application. There was evidence that efforts were ongoing to recruit staff. The inspectors found that since the application for registration was submitted in May 2021 eleven staff members had left following either resignation from their post, internal transfer or did not take up the post following the recruitment process. The inspectors found that 15 individual staff members had completed shifts on the roster since the young person's admission on 29th July 2021. Staff rosters from 02nd August to 07th November were reviewed by the inspectors. There was evidence of ten back-to-back shifts and staff were working overtime most weeks. Staff working in the centre were frequently not getting sufficient rest at night-time and were working on average three, and sometimes four, sleepover duties across seven days. Staff were informed it was unlikely that any annual leave could be facilitated before the end of the year until the staffing situation had been resolved. The registered proprietor must ensure that staff have sufficient rest periods between shifts and while on shift to ensure health and safety obligations are met by the proprietor. The registered proprietor informed the inspector that they had two staff members ready to commence employment by the 17th of November 2021 following completion of their mandatory training. Despite all the staffing difficulties the inspectors found that morale was good within the team and the staff were all pulling together to work through this difficult period where there were depleted staffing resources.

The inspectors also found that only two members of the team and the relief staff member had the required qualification therefore the centre did not meet the

requirement set down by Tusla that, at a minimum, 50% of the staff team must have a recognised qualification in social care practice.

There was evidence that the registered provider received feedback from staff about their work through supervision and through the external consultant who met the team on a fortnightly basis. There were no exit interviews undertaken with staff who had recently resigned. The registered provider must improve the practice in relation to undertaking exit interviews with staff prior to them leaving the organisation.

Following a review of a sample of staff supervision files the inspectors found that staff had not received support and supervision in their work through the forum of regular and formal supervision. Some staff members had not received supervision within the timeframes set out in the centre's supervision policy. Other staff had several different supervisors across their supervision sessions. There was also evidence of staff supervision alternating between the managers in the centre. While inspectors accept this was unavoidable with the turnover of managers, the inspectors recommend that staff have a dedicated supervisor, and that staff supervision does not alternate for individual staff between the deputy and the centre manager.

A sample of personnel files were reviewed by the inspectors. Overall, personnel files were well maintained, and information was accessible in terms of file set up. There was evidence of an induction process including policy and procedure and risk assessment training. There was one deficit in the vetting requirements where a staff member did not have the required overseas police check on file and several personnel files did not have evidence that the required mandatory training had been completed. The registered proprietor must ensure a full and complete audit of all personnel files is undertaken to ensure all the required documentation is maintained on each personnel file.

The staff had access to two external professionals to support them in their work. The staff had access to an employee support service that they could access free of charge and independently. One of the external consultants met with the team monthly to provide a space for staff to reflect on the impact of their work and to discuss self-care. This consultant also was available to staff to provide individual counselling. Supervision of staff provided them with the opportunity to review their employment, how they felt about their work, their happiness in their work and the additional supports they required.

There was an on-call system in place to support staff after hours and at weekends. There was a written policy in relation to on-call and guidance for staff when to use on-call support and recording all decisions and directions provided by the on-call manager. A review of the staff rosters indicated that on call was provided on a rotational basis between the registered proprietor, centre manager, deputy manager, and team leaders.

The inspectors found that Regulation 7 of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 in relation to staffing were not met at this time.

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

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

Actions Required:

- The registered proprietor must ensure that there are appropriate numbers of staff employed in the centre with regard to the requirements of Tusla alternative care inspection and monitoring service and the centre's statement of purpose.
- The registered proprietor must ensure there are sufficient numbers of staff with a recognised qualification in social care practice.
- The registered proprietor must ensure there are a sufficient number of suitably qualified and experienced relief staff available to provide contingency cover for emergencies, sick leave and annual leave as it arises.
- The registered proprietor must ensure that all staff receive regular formal supervision in line with centre policy.
- The registered provider must have a more robust system in place to undertake exit interviews with staff prior to them leaving the service.

- The registered proprietor must ensure a full and complete audit of all staff personnel files is undertaken to ensure all the required documentation is maintained on each personnel file.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	N/A		
5	The registered provider must ensure that leadership roles at every level within the centre are filled and the management structure is stabilized going forward.	A new team leader commenced employment on the 20.12.21 and another is due to start on the 10.01.22. New job applicants will be interviewed on 11.01.22. Vacant positions aimed to be filled by end of February 2022.	Business development and recruitment manager was appointed on 29.11.21. A panel of applicants will be established and used to fill future vacancies. The launch of a page will aid advertising future jobs. The organisation will take students for placement from the local third level college to increase the profile of the company and develop links with future employees.
	The registered proprietor must ensure there are adequate systems in place for the external oversight of care practices in the centre and to assess the centre's compliance with the national standards while the quality assurance officer is on leave.	The centre manager from another centre in the organisation will conduct external audits against the National Standards at the end of each month within the centre, commencing end of January 2022. The registered proprietor will oversee the completion of the audits in conjunction with the business development and	The registered proprietor and managers will review the audits during senior management meetings commencing February 2022. The quality assurance and governance manager will resume their post beginning of June 2022, at which time the quality assurance and governance manager will

		recruitment manager.	resume responsibility for audit completion.
	The registered provider must ensure that the appointed centre manager has the required qualification and the required level of experience working with children in residential care.	The acting manager is in post until a new manager is recruited. Timeline of completion end April 2022.	No centre manager going forward will hold the post without the required qualification and the required level of experience working with children in residential care.
	The registered provider must ensure that the governance systems in place are in compliance with the centres' policies. Senior management meetings, management meetings and team meetings must be carried out in line with centre policy.	With immediate effect all meetings will take place in accordance with the company policy.	The registered proprietor will require a schedule of all meetings and minutes of each meeting to be uploaded onto the electronic information management system within two days of meetings taking place. The registered proprietor will chair the senior management meetings. The quality assurance and governance manager will chair the senior management meetings in the absence of the registered proprietor. This standard will be included in the external audit.
	The registered proprietor must set out a clear timeframe for the review of all operational policies	This is currently being developed. Completion target date is the end of January 2022.	Once developed these policies will be reviewed on a yearly basis at the senior management meetings, commencing

	to ensure they meet the requirements of the national standards and the child safeguarding policy must also be updated in line with Children First, 2017. The registered provider must ensure there are more robust and frequent reviews of the individual risks associated with the young person's behaviour as outlined in the centre's risk management policy.	Risk assessments will be stored and reviewed in terms of priority and probability of risk occurring. All risk assessments will be reviewed on monthly basis, amended, or archived if required.	January 2023. Managers will store risk assessments giving priority to the most salient identified risk. These will be examined during senior management meetings and team meetings. This task to be included in external audits.
6	The registered proprietor must ensure that there are appropriate numbers of staff employed in the centre with regard to the requirements of Tusla alternative care inspection and monitoring service and the centre's statement of purpose.	A new team leader started on the 20.12.21 and another staff member is due to start on the 10.01.22. Applicants being interviewed on 11.01.22. Vacant positions aimed to be filled by end of February 2022.	Business development and recruitment manager was appointed on 29.11.21. A panel of applicants will be established and used to fill any future vacancies. The launch of a social media page will aid advertising future jobs. The organisation will take students for placement from the local third level college to increase the profile of the company and develop links with future employees.

	The registered proprietor must ensure there are sufficient numbers of staff with a recognised qualification in social care practice.	The registered proprietor will ensure 50/50 spilt and continue to prioritise the recruitment of Health and Social Care / Social Work Northern Ireland applicants.	The business development and recruitment officer will liaise with the local third level college in January 2022 and agree a student placement programme for the children's residential centre. The business development and recruitment officer to analyse and identify the most productive methods for recruiting Health and Social Care/ Social Work Northern Ireland as employees. The recruitment strategy will be presented at senior management meetings monthly for update and discussion. The business development and recruitment officer will liaise with the local third level college in January 2022 and agree a student placement programme for the children's residential centre.
	The registered proprietor must ensure there are a sufficient number of suitably qualified and experienced relief staff available to provide contingency cover for emergencies, sick leave and	Applicants being interviewed on 11.01.22 for relief positions.	The business development and recruitment officer to analyse and identify the most productive methods for recruiting Health and Social Care/ Social Work Northern Ireland as employees. The recruitment strategy will be presented

	annual leave as it arises.		at senior management meetings monthly for update and discussion.
	The registered proprietor must ensure that all staff receive regular formal supervision in line with centre policy.	Managers will ensure all staff will receive supervision in line with company policy, with immediate effect.	Managers will present evidence of completing supervisions at senior management meetings.
	The registered provider must have a more robust system in place to undertake exit interviews with staff prior to them leaving the service.	Managers will seek to complete exit interviews with staff prior to the leaving the service. This has already commenced.	All exit interviews will be undertaken by the business development & recruitment manager from January 2022. Information arising from the exit interviews will be collated and presented to the senior management meeting for discussion and to identify remedial action.
	The registered proprietor must ensure a full and complete audit of all staff personnel files is undertaken to ensure all the required documentation is maintained on each personnel file.	Managers will ensure audit of all staff personnel files are completed by 10.01.22. This has already commenced.	Managers will present evidence of completing this audit at senior management meetings.