An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 218

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Fresh Start Ltd**
Registered Capacity:	**Three Young People**
Type of Inspection:	**Unannounced**
Date of inspection:	**09th, 10th & 11th August 2023**
Registration Status:	**Registered from 23rd March 2023 to 23rd March 2026**
Inspection Team:	**Linda McGuinness** **Ciara Nangle**
Date Report Issued:	**11th October 2023**

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 on the 23rd March 2023. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from the 23rd March 2023 to the 23rd March 2026.

The centre was registered to provide medium term care for three young people between the ages of thirteen and seventeen on admission. The centre was established under a new pilot project commissioned by Tusla's CRS National Private Placement Team as a step-down service to cater for young people who were leaving special care or in need of a placement in special care.

Inspectors found that the centre was not operating under a model of care. This is addressed further in the report under Theme 3 of the National Standards for Children's Residential Centres, 2018 (HIQA). There was one young person living in the centre at the time of the inspection. A second young person had been admitted on 28th July 2023 from special care but had been returned to special care on 08th August 2023 as the centre did not have enough staff meet the needs of the children in the centre and the centre's statement of purpose and function. Service managers stated that it was their intent to re-admit that young person once they had recruited sufficient staff and stabilised the operation of the centre.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.2 only
6: Responsive Workforce	6.1 only

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 21st August 2023. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 5th September 2023.

The findings of this report and assessment of the submitted CAPA deem the centre not to be 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 16 *Notification of Significant Events*. The centre has been unable to maintain a consistent staff team to meet the needs of children residing in the centre.

As such, It is the decision of the registration committee to attach a condition to the centre's registration under Part VIII Article 61 (6) (a) (i) of the Child Care Act 1991. The condition being:

- There must be no further admissions of a young person under 18 to this centre until assurances are received and evidence that the number, qualifications, experience, and availability of members of the staff of the centre are adequate having regard to the number of children residing in the centre and the nature of their needs.

The registered capacity for this centre remains at three. As agreed at the Regulatory Enforcement Meeting on 21st August 2023, due to staffing and other governance matters, the centre can only currently accommodate one young person. The above condition outlines that there must be no further admissions which would increase the number of young people in the centre above one.

This condition will be attached to the registration of the centre from the 3rd October 2023 and will be reviewed on receipt of evidence of compliance or before the 4th December 2023.

3. Inspection Findings

Regulation 5: Care practices and operational policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

This inspection activity was initiated following an escalation received by Tusla's National Private Placement Team. Through this review and from contact with external line managers for the centre, inspectors established that there had been a number of very serious incidents and that there had been significant turnover in the staff team. Issues relating to staffing are dealt with below under Theme 6: Responsive Workforce.

Inspectors found that there were policies and procedures in place that directed the staff and managers in the management of challenging behaviours. It was observed that these were aligned to the organisation's policies rather than specific to the centre, which was established under a pilot project as a step-down service to deliver increased levels of care and support. As such, inspectors found that the policies and procedures in place did not adequately direct or support the staff team to address the behaviours of young people as they were designed for a mainstream community-based children's residential centre, rather than a step-down service.

As noted previously in this report, the centre did not have a written model of care that directed staff in their interactions and interventions with young people. Each staff member interviewed was unclear on the model in use and there was no written information available to staff to direct them. Further, training records reflected that staff had not received training in a model of care. The centre manager stated that the programme for the centre would be developed by September 2023 and that training would subsequently be provided in this model to staff. However, given that the centre was first granted a registration in March 2023, it is the finding of inspectors that this is not sufficient, and the centre cannot operate without direction to the staff on the model of care and interventions to be used with young people.

Centre policy was that a therapeutic assessment would be conducted by the organisation's clinical team with each young person within the first 12 weeks of their

placement. However, inspectors found that this had not occurred and from interview also ascertained that there was no plan by the clinical team to complete an assessment with either young person.

Inspectors found from interviews and from a review of records that a recognised model of de-escalation and physical intervention was in place. This model provided strategies to address challenging and crisis behaviours. However, while the majority of staff had received core training, inspectors found that the organisation provided no evidence of assessment of competency of physical interventions every six months as certificates were only issued annually.

Inspectors observed that the individual crisis support plans for both young people stated that physical interventions could be used as a last resort. However, for one young person a contra indication to restraint was also included and, from interviews and a review of care records, concerns were expressed by staff about their ability to safely perform physical restraint with them. Inspectors did not see evidence that external professional advice was sought in relation to this, including medical advice.

On the second young person's ICSP from August 2023, it noted that the young person may require a daily restraint to support regulation which is not permitted under the model of behaviour management in use. Additionally, from the significant event notifications reviewed, it was found that restraint was being used to support regulation rather than as a last resort to ensure safety of the young person and staff and this requires an immediate review to ensure physical interventions are being used appropriately.

As part of this inspection, the inspectors reviewed pre-admission information for young people. Among this information was a report that stated that one young person required a mature, stable and consistent staff team with experience working in a step-down setting, to support them. Inspectors found that six staff members, the centre manager and the external line manager for the service had all left their posts since the first young person was admitted in May 2023. Inspectors also found that the staff team allocated to this centre had limited experience with young people in residential care that displayed challenging behaviours. This was not congruent with the nature of the pilot service to be operated or the needs of the young people to be admitted. Additionally, inspectors found that due to the inexperience of the staff team and the anxiety they expressed at team meetings and in supervisions, the manager and deputy often worked on the floor alongside staff and young people. This diluted their capacity to properly fulfil the management function.

Senior managers for this centre acknowledged that staffing within the centre was an immediate issue. As a result of the staffing crisis in the centre, one young person's placement was ended, and they were returned to special care. This decision was as a result of the centre being unable to provide enough staff with the necessary skills and experience to care for the young people that were placed with them. At times, the centre was relying heavily on agency staff or staff from other centres in the organisation so that it could continue to operate.

Further, inspectors found that adequate recording and reporting processes were not in place and new staff coming into the centre were not provided with sufficient information to support them to effectively care for the young people.

Inspectors observed that a number of risk assessments in place did not accurately describe the risk posed to young people. In some instances, measures written in as controls were not put in place or could not be implemented. These risk assessments were not being adequately reviewed by external line managers or the clinical team and could not be properly implemented in the centre. Inspectors found that there was a risk register in place; however, some existing risks for young people and the operation of the centre were not included on this and it should be revised by the regional manager for this centre to ensure that it is up-to-date and accurate.

From a review of training records, inspectors did not see specific training for staff in relation to the individual needs of the young people. While training needs were discussed at staff team meetings and within supervisions, no extra training was provided. Given the complex and trauma-based behaviours of the young people, additional training should have been provided to the staff team in respect of issues such as self-harm, suicide awareness, mental health and substance misuse for example.

While inspectors acknowledge that Tusla's Assessment Consultation Therapy Service (ACTS) had agreed to continue to work with young people for a period after their admission, there was no plan to transfer oversight of the care of young people to this organisation's clinical team. Further, the availability of ACTS staff to support the needs of young people on a daily basis (which was required in this centre) was limited. ACTS staff were not in a position to review crisis management plans, significant event notifications or placement plans. This work should have been carried out by the organisation's clinical team. Inspectors reviewed documentation which indicated a variety of reasons for the lack of involvement of clinicians from this organisation including that it was a capacity issue. Despite one young person being

in placement for 12 weeks, and the clinical team did not attend core group meetings which would aid in this handover process.

Inspectors noted that key work plans for one young person were not on file and there was no placement plan present. As such, inspectors could not determine what work was due or planned for completion with this young person to support them in understanding their behaviour. The other resident young person had a placement plan and key working plans and inspectors saw some evidence of work being completed with this young person. Inspectors observed warm supportive interactions between the young person and the deputy social care manager who they named as a key person to support them when there were a lot of staff changes.

From a review of documents, inspectors found that there was insufficient information contained on the absence management plans, crisis support plans, placement plans, key working plans and weekly planners for young people. The recording practices and the standards of records and care files were not acceptable. Issues were found as follows:

- Copy and pasting within documents resulting in the wrong young person's name/information being included resulting in data protection issues.
- Loose documents within files.
- An incomplete file for one of the young people
- The language used in the records was not what was agreed at the outset of placement and could contribute to the cause of challenging behaviour should a young person exercise their right to access their record.
- Visitors log was not accurate which may present as a safeguarding issue.
- Placement plans not on file during inspection.
- Centre registers significantly out of date.
- SENS not appropriately written or recorded and not notified.
- Risk assessments not accurately describing the risks to young people.
- Some daily logs not written up and not on file.

Inspectors also had difficulty in determining who was on shift each day as the daily logs were not clear what shift each person was working and often there were references to the "care team" rather than the interactions or interventions of specific persons. Further, the rosters provided did not always reflect who was on shift. The accuracy of daily logs and rosters are important safeguarding elements for young people. The accuracy and availability of accurate information to the staff working in

the centre supports effective care being delivered. The standard of recording and reporting in the centre must be immediately addressed by the registered provider.

Inspectors reviewed a sample of audits completed by the previous external line manager for the centre. However, an audit under Theme 3: Safe Care and Support of the National Standards for Children's Residential Centres, 2108 (HIQA) had not been completed to date. The centre manager advised that the organisation's Quality Assurance and Practice Manager was due to commence auditing in the centre in August 2023.

While the organisation had processes in place for regular significant event review groups (SERG), the processes were not in place for this centre. As noted there had been a number of very serious incidents in the centre and SERG meetings should have been convened. However, these did not occur. The registered provider must ensure that SERG are held where necessary to ensure improvements in care practices and that risks to young people are appropriately assessed and managed. In the absence of SERGs, there was no mechanism to track or analyse patterns and trends relating to incidents which may have provided the team with information around triggers and approaches to practice that were proving effective or ineffective. There was some evidence of post-crisis reviews with team members following serious incident however, there was no evidence that any learning from this process was communicated to the wider staff team.

Inspectors found that there were restrictive procedures in place within the centre. However, there was no evidence that these practices were being adequately risk assessed and reviewed within the centre or by external line managers. Further, inspectors found that the recording and reporting of restrictive practices was insufficient in the centre. The regional manager for this centre must ensure that the care records for young people adequately detail why and when the restrictive practice was implemented and how it is being reviewed.

Given the findings of this inspection, it is the assessment of inspectors that the operation of the centre is not in keeping with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies or Article 16: Notification of Significant Events.

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

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

Actions required:

- The registered provider must ensure that there is a written evidenced based model of care to guide practice in the centre.
- The registered provider must ensure that staff are competent to deliver the model of care and that its effectiveness is reviewed regularly.
- The registered provider must ensure that the statement of purpose reflects the day-to-day operation of the centre and that appropriate governance arrangements are in place to ensure accountability for realising this in practice.
- The registered provider must ensure that policies and procedures in place are reflective of the operation of the service and implemented in practice.
- The registered provider must ensure pre-admission risk assessments reflect all identified risks set out in referral information.
- The registered provider must ensure that there is evidence that staff have demonstrated competency in the physical aspects of the model of behaviour management in use.
- The centre manager must ensure that any physical intervention in the centre is in line with the recognised model of de-escalation and physical intervention in place. Medical advice must be sought when required and staff must be clear about any contraindications to the use of physical restraint.
- The registered provider must ensure that there is a full review of recording and reporting process within the centre to ensure these are effective.
- The register provider must ensure that daily logs and rotas include accurate information in respect of staff working with young people in the centre.
- The centre manager must ensure that all young people have an up-to-date care file, with all relevant information to support staff to effectively care for the young people.

- The centre manager must ensure that significant event notifications are issued in a timely manner.
- The registered provider must ensure that staff in the centre have up-to-date knowledge and skills appropriate to their role, have access to specialist advice and appropriate support and training to meet the needs of young people.
- The centre manager must ensure that all restrictive practices and procedures are adequately risk assessed, appropriately recorded, reviewed and notified to relevant persons.
- The registered provider must ensure that SERG meetings are convened where necessary to ensure improvements in care practices and that risks to young people are appropriately assessed and managed.
- The register provider must ensure that clinical supports proposed in application for registration and statement of purpose are implemented within the centre.

Regulation 5: Care Practice and Operational Policies
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.

As noted, six staff members had resigned from their posts since the admission of the first young person in May 2023. The centre manager had also left their post as had the external line manager. At the time of the inspection, the centre was experiencing an acute staffing crisis and relying on agency staff and staff from other centres in the organisation to continue to operate. The inspector manager asked for and received written assurances from the registered proprietor on the continued viability of the centre on 11th August 2023.

Inspectors found that workforce planning was occurring at management meetings. Inspectors saw evidence of the centre manager discussing work force issues during these meetings and highlighting the need for more staff. Inspectors could also see workforce being discussed during team meetings to ensure shifts were covered within the centre. It should be noted that registration was granted for this centre against a specific staff list, however, one staff member did not start work in this centre. Additionally, the application for registration for this centre did not accurately

describe that two staff were not working wholetime equivalent posts and were working reduced hours with agreement of management.

At the time of inspection there was only three full time staff members available to work in the centre. The remainder of the team had resigned or were on sick leave. The centre had commenced operations without employing any relief staff and therefore the centre manager immediately struggled to cover all types of leave. Inspectors found that agency staff who worked in the centre were not provided with appropriate information to care for the young people and manage risk. Inspectors found that the newly appointed deputy manager did not have up to date Garda Vetting on file, and the educational tutor was employed and commenced working in the centre without appropriate vetting in place.

As part of the registration process, the registered provider had given assurances that a shift leader system would be implemented in this centre. However, inspectors found that this shift leader system was not in place at the time of inspection.

From a review of the personnel files, it was evident to inspectors that a limited number of the team had previous experience in working in residential care. This was not in line with the statement of purpose for the centre and its registration under the new pilot project. As noted above, while staff had completed mandatory training, additional training in areas specific to the needs of the young people had not been provided. The staff underwent a six-week induction to the service; however, there was no evidence of additional or specific training provided during this period.

Inspectors found that during the period 01st July 2023 – 08th August 2023, 22 different staff members had worked in the centre. This is in the context of two young people who required consistency within the care provision which is difficult to provide when the staff team is changing. The shift pattern in place was two sleep overs and one day shift. However, in interviews and from a review of records, inspectors found that the centre struggled to fill the three shifts due to sick leave.

Inspectors found that one young person was informed that an agreed intervention could not be used as there was only one core staff member working alongside an agency staff member. Another young person had their access arrangements with family members impacted by a lack of staffing. They used the complaint process, and their complaint was upheld however deficits in staffing remained an issue at the time of inspection and the negative impact on the care of young people was clearly evident.

Inspectors spoke with social workers and Guardians ad Litem for both young people as part of the inspection process. All reported that they had been unaware of the staffing issues within the centre, and the impact this was having on the care provision or administration within the centre. They advised that the preadmission risk assessment process initially did not identify all risks, however they were involved in the further exploration of this. Both teams did not have clarity on the role the clinical team would take on in regard to the young people's future care and concerns were expressed by the Guardians ad Litem about the teams awareness of the needs and previous assessments completed with both young people.

One social work team acknowledged that the provision of a care plan to the centre was significantly delayed due to resource issues and they committed to addressing this as a matter of urgency. There was evidence however that they were in regular communication with the management in respect of planning for their young person.

Inspectors noted that team meeting minutes and management meeting minutes recorded the concerns of the staff team in relation to the impact of the admission of a second young person on the operation of the centre. However, despite staff raising these concerns, inspectors could not see what actions were taken to minimise this impact and reduce staff concerns or worries around this. Consequently, a number of staff members submitted resignations and in the one exit interview completed, there was links to the impact this admission had.

Supervision was occurring in line with policy, however again issues were being raised in relation to the impact the work was having on staff and limited actions were recorded to address this or support the staff member and consequently retention. Inspectors noted that management had made requests for training, SERGs and clinical supports however these were not implemented in a timely manner and inspectors could see a direct correlation between this and staff retention.

Inspectors found that there was an on-call policy in place for the centre. Records for this reviewed indicated this was being used appropriately.

Given the findings of this inspection, it is the assessment of inspectors that the operation of the centre is not in keeping with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies or Article 7: Staffing.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5** **Regulation 7**
Compliance with standards	
Practices met the required standard	**None Identified**
Practices met the required standard in some respects only	**None Identified**
Practices did not meet the required standard	**Standard 6.1**

Actions required:

- The registered provider must ensure that there are appropriate numbers of staff employed with regard to the statement of purpose and number and needs of young people, to be in compliance with the Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 7: Staffing.
- The registered provider must ensure there is a panel of suitably qualified relief staff to provide cover for annual and unplanned leave.
- The registered provider must ensure that there is an operational shift leader system in place in accordance with commitments given as part of the centre's application for registration.
- The registered provider must ensure that exit interviews are conducted with staff who leave the centre and that information is analysed to inform workforce planning.
- The registered provider must ensure that there is an effective staff retention programme in place.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again with Time Scales
3	The registered provider must ensure that there is a written evidenced based model of care to guide practice in the centre.	Strategy meeting held on 24/08/2023 between centre management and senior management. The registered provider will ensure that the model of care is written and implemented by 30/09/2023.	The registered provider will ensure that the model of care is implemented in consultation with the organisations clinical team to guide practice and ensure the continued clinical input and clinical oversight of the centre in line with the centre's policies and procedures.
	The registered provider must ensure that staff are competent to deliver the model of care and that its effectiveness is reviewed regularly.	Training will be provided to the care team to ensure competency in the delivery of the centre's model of care. To be completed by 30/09/23	Training will be provided in line with the organisation's induction programme to ensure all newly appointed staff to the centre are trained in the centre's model of care. The model of care will be reviewed in house as part of team meetings and staff supervision. Centre management and senior management will monitor the effectiveness of the delivery of care in the centre. Monthly MDT meetings with the

			clinical team will also occur.
	The registered provider must ensure that the statement of purpose reflects the day-to-day operation of the centre and that appropriate governance arrangements are in place to ensure accountability for realising this in practice.	Senior management team are currently reviewing the statement of purpose for the centre which will be finalised by 08/09/23 Governance audits were carried out on the centre by quality assurance manager on 22/08/2023 and regional manager on 28/08/2023. Centre management team are implementing weekly governance arrangements which commenced on 28/08/2023 to ensure accountability and oversight within the centre.	Centre management and senior management will ensure regular review of the centre's statement of purpose in line with organisational policy and procedures. (Organisational auditing schedules implemented immediately to ensure accountability of the centre's governance). The centre will be subject to monitoring by the regional manager and quality assurance manager to ensure appropriate governance arrangements are and remain in place.
	The registered provider must ensure that policies and procedures in place are reflective of the operation of the service and implemented in practice.	Strategy meeting held between centre management and senior management on 24/08/2023. The registered provider will ensure that centre specific policies and procedures are implemented by 30/09/2023.	The registered provider will ensure that the policies & procedures document is reviewed on an annual basis or as required to ensure it is compliant with required standards and best practice guidelines.
	The registered provider must ensure pre-admission risk assessments reflect all identified risks set out in referral	Centre Manager will ensure that referral information is thoroughly reviewed, and all risks identified are recorded on the pre-	Centre manager in collaboration with regional manager will ensure that all pre-admission risk assessments reflect all

	information.	admission risk assessments.	identified risks set out in referral information when submitting placement proposals.
	The registered provider must ensure that there is evidence that staff have demonstrated competency in the physical aspects of the model of behaviour management in use.	All staff members are appropriately trained and certified in the physical aspects of the model of behaviour management via Level 7 training of the behaviour management programme which is mandatory for all staff members. Each staff member completes a recertification every 12 months and a corresponding refresher every six months.	Annual training planners schedule all staff members for refresher and recertification in the organisational model of behaviour management. Centre manager will ensure that all staff members attend annual training in line with organisational policy and procedures. An updated cert is placed on staff files upon completion of their yearly recertification. A record is also kept of each six-month refresher.
	The centre manager must ensure that any physical intervention in the centre is in line with the recognised model of de-escalation and physical intervention in place. Medical advice must be sought when required and staff must be clear about any contraindications to the use of physical restraint.	Completed. Medical advice sought in relation to the use of physical intervention with young person currently in placement. ISCP reviewed with behaviour management programme monitor and the staff team during team meeting on 22/08/2023. Safety plans implemented on 22/08/2023 in line with model of behaviour management.	The centre manager will continue to ensure that all staff are fully competent in the model of behaviour management. The ICSP is subject to monthly reviews by the behaviour management programme monitor and any contraindications to the use of physical restraint will be clearly identified and recorded.

	The registered provider must ensure that there is a full review of recording and reporting process within the centre to ensure these are effective.	The Centre Manager and Regional Manager have commenced a review of current recording and reporting process within the centre which will be completed by 30/09/23.	The centre manager with support from the regional manager will ensure that all recording and reporting procedures are adhered to in line with the companies' policies and procedures and national standards. The centre will also be subject to auditing by the QAM whereby any deficits will be identified and rectified promptly.
	The registered provider must ensure that daily logs and rotas include accurate information in respect of staff working with young people in the centre.	The centre manager will ensure daily oversight of the recording of daily logs. Centre manager has implemented rosters to ensure accurate information of staff working with young people is recorded in the centre. Immediate and ongoing.	The centre manager will ensure that any staff working in the centre are clearly recorded on monthly rotas and information on all staff working with the young people is obtained and recorded on all relevant centre records.
	The centre manager must ensure that all young people have an up-to-date care file, with all relevant information to support staff to effectively care for the young people.	Completed on 01/09/2023. Daily filing systems implemented, and all young people's care files are appropriately up to date.	Centre manager will ensure monthly governance of young people's care files to ensure all relevant information to support staff to effectively care for the young people is appropriately filed and accessible.

	The centre manager must ensure that significant event notifications are issued in a timely manner.	Completed. The centre manager is ensuring that significant event notifications are being submitted in a timely manner in line with requirements.	The centre manager will ensure that all significant events are notified within 3 days and an up-to-date register of significant events notifications is maintained to evidence and monitor the timeframe of the submissions of SEN's.
	The registered provider must ensure that staff in the centre have up-to-date knowledge and skills appropriate to their role, have access to specialist advice and appropriate support and training to meet the needs of young people.	A strategy meeting was held with the clinical team on 30/08/23 to discuss the deficits and lack of clinical support to the centre. Arrangements are currently being implemented to ensure that the care team will be supported by members of the clinical team to have the knowledge, skills and training appropriate to their role commencing with training scheduled for the staff team with the organisation's consultant psychiatrist on 06/09/2023.	The registered provider will ensure that the care team receive regular and adequate support and specialist advice, support, and training to meet the needs of the young people. This will be done via monthly MDT meetings and direct support from the organisation's clinical psychologist.
	The centre manager must ensure that all restrictive practices and procedures are adequately risk assessed, appropriately recorded, reviewed and notified to relevant persons.	The centre manager has commenced an audit of the centre's restrictive practices and procedures to ensure all are appropriate with accompanying risk assessments, are clearly recorded,	The centre manager will ensure that all restrictive procedures and associated risk assessments are appropriately reviewed with the staff team during fortnightly team meetings to assess the level of risk in place.

		reviewed, and notified to relevant persons. This will be completed and shared with relevant persons by 08/09/2023.	The centre manager will ensure that all relevant people are notified of any changes pertaining to same.
	The registered provider must ensure that SERG meetings are convened where necessary to ensure improvements in care practices and that risks to young people are appropriately assessed and managed.	The centre manager will ensure that all significant events are reviewed as per Post Crisis Review Policy and Post Crisis Review Meetings (SERG meetings) arranged where necessary.	The centre manager with support from the clinical team will ensure that PCR meetings (SERG meetings) are convened in line with Organisational behaviour management Policy.
	The register provider must ensure that clinical supports proposed in application for registration and statement of purpose are implemented within the centre.	The centre will be supported by a clinical psychologist and behaviour management programme monitor who will support the team with all aspects of care planning for the young people. Immediate and ongoing.	The registered provider will ensure that the clinical supports proposed in the application for registration and in the statement of purpose remain in place and provide regular support and guidance to the team as required.
6	The registered provider must ensure that there are appropriate numbers of staff employed with regard to the statement of purpose and number and needs of young people, to be in compliance with the Child Care	The registered provider has voluntarily reduced the occupancy level within the centre to ensure that appropriate numbers of staff are employed to meet the needs of the young people. Recruitment remains ongoing at present to increase staffing	A recruitment drive remains active at present to boost the current staffing levels within the centre to meet that set out in the statement of purpose. The registered provider will ensure that work force planning continues to occur to ensure the

	(Standards in Children's Residential Centres) Regulations 1996, Part III, Article 7: Staffing.	levels. Immediate and ongoing.	appropriate number of staff are employed in the centre.
	The registered provider must ensure there is a panel of suitably qualified relief staff to provide cover for annual and unplanned leave.	The registered provider is actively advertising for the recruitment of suitably qualified relief for the centre. Immediate and ongoing.	A recruitment drive remains active at present to boost the current staffing levels within the centre. The registered provider will ensure that a panel of suitably qualified relief staff is in place to provide cover for the centre as required.
	The registered provider must ensure that there is an operational shift leader system in place in accordance with commitments given as part of the centre's application for registration.	Effective from 01/09/2023, the centre manager has ensured that an operational shift leader system is in place within the centre. Ongoing.	The registered provider will ensure that operational shift leader systems are maintained within the centre in line with the centre's application for registration.
	The registered provider must ensure that exit interviews are conducted with staff who leave the centre and that information is analysed to inform workforce planning.	Two staff members have withdrawn termination of employment and returned to work in the centre. In respect of two other staff who have left the centre, both were offered exit interviews, one of whom availed of this while the other declined.	The HR department ensures that all staff are offered an exit interview upon resigning from their employment. All exit interviews are in turn planned and conducted with staff who leave which is then shared with the relevant manager to inform workforce planning.

	The registered provider must ensure that there is an effective staff retention programme in place.	There is a comprehensive employee assistance programme with benefits for staff in place to promote retention of staff. Specific focussed support is being prioritised for staff within this centre to support them in their day-to-day work.	Employee staff retention initiatives are regularly reviewed within the organisation by the registered provider and the senior management team.