An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 003

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Fresh Start Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**24th & 25th of January 2023**
Registration Status:	**Registered from the 8th of April 2023 to the 8th of April 2026**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**9th May 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 8th of April 2011. At the time of this inspection the centre was in its fourth registration and was in year three of the cycle. The centre was registered without attached conditions from the 8th of April 2020 to the 8th of April 2023.

The centre was registered to provide multi occupancy for up to a maximum of four young people of all genders between the ages of thirteen to seventeen upon admission. The centre had recently moved, on the 14th of December 2022, to a new premises and new location. The property was deemed compliant with the relevant regulations and the registration certificate was duly updated. The centre operated a needs assessment model of care with the aim being to offer children a safe caring environment delivered through a nurturing system. The model is described as being trauma informed with a positive focus, having clearly defined boundaries and expectations that responds to the child's immediate needs. 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 & 3.2
4: Health, Wellbeing and Development	4.2
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 on the 20th of February 2023 and to the relevant social work departments on the 20th of February 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 6th of March 2023. This was deemed to be require more detail and information and an updated CAPA was requested from the centre manager, a meeting held to clarify key points. An updated CAPA was provided on the 16th of March 2023 that was satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 003 without attached conditions from the 8th of April 2023 to the 8th of April 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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.

Inspectors reviewed a set of updated policies and procedures created by the organisation during two review periods in July and in November 2022. The child protection and safeguarding policy suite was created in line with Children First and other relevant legislation. The policies had been circulated to the centre and cascaded down from the social care manager to all staff. Inspectors found that the staff and management displayed effective knowledge on what policies underpinned organisational structure and accountability in child protection and safeguarding, for example safe recruitment practices. The centre's regional manager tracked with the social care manager the roll out of the revised policies and had directed that more specific and detailed attention to this process be applied in the first quarter of 2023. Inspectors also found that work was required for the team to have time to dedicate to the changes to the policy document and its new layout.

Inspectors did find that staff knew their roles and overall responsibilities under Children First as mandated persons and were clearly aware of the designated persons role and who held that role. In this instance the social care manager was the DLP with their deputy manager being the deputy DLP. The staff had completed mandated persons training online as had the management regarding the DLP role. The policies clearly identified the roles and responsibilities also.

The policies were scheduled for further review in 2023 and inspectors found that there were areas such as allegations against a staff member that varied slightly in emphasis between two sections and should be clarified to ensure they are unified regarding the procedures identified in the two sections. The centre management agreed to refer this to the next policy review meeting.

The team had been submitting child protection reports though the dedicated portal in accordance with their assessment of issues of concern. Inspectors identified that as a technical issue the centre was creating a copy of the record with an 'unsubmitted' status and have requested that they contact Tusla ICT portal support to seek guidance on how to generate a copy of the submitted version for the centre's confidential records. There was also evidence that the team must take time, with their internal

trainer and management to review the extent of the information recorded on the reports as inspectors found that the contents were very limited. There was evidence that as a team they must review their understanding of the thresholds for concern against the records submitted to identify areas of learning.

The centre's child safeguarding statement had been updated to reflect their new location and new admission with a copy submitted and returned from the child safeguarding statement compliance unit which deemed it to be in ongoing compliance. There was a copy on display at the centre. The team were aware of the risks identified within this but were not fully aware of the roles and persons within it also with regard to who was the Relevant Person for example.

The staff stated that they were trained in the Tusla eLearning module: Introduction to Children First and in the mandated persons module and this was verified through the certificates for same. They also stated that they had completed training internally in the centres own child protection policies and procedures. Inspectors found that staff and management had difficulty though recalling exactly when these trainings were done, the training record was maintained in a 'non mandated training' log. Inspectors recommend that mandatory training record be updated to contain the Tusla modules done and their renewal dates as well as the organisational child protection training done. There was a commitment in the policies to a 'Child Safeguarding Training Strategy inclusive of accessing, delivery, monitoring, evaluating' and some of this was captured through the quality assurance managers audit but had not been defined in line with the strategy.

There was a policy on anti-bullying contained within the policy document, there was no evidence reported or identified of bullying in the centre. Inspectors found that the team displayed some gaps in policy knowledge and should review these regularly together as a group and in supervision to ensure a consistent approach to use of language and terms to support young people's development of insight and understanding.

Overall, the inspection found that there was less confidence on record and in interview on how safeguarding on areas of vulnerability translated into practice for each of the young people alongside the core use of an individual crisis support plan, the ICSP and the individual absence management plan, the IAMP. Inspectors found that whilst both were key components and reviewed regularly with input from the clinical co-ordinator, the social workers, and the young people on occasion, that there were gaps in capturing and then implementing areas of direct work with the young people aimed at developing their ability to self protect over time. There was insufficient direct evidence that the young people were being supported to have insight into their own areas of vulnerabilities in accordance with their age and ability.

The social workers for the young people were satisfied with the work ongoing and they found that there was evidence that the young people were encouraged to speak up and talk to staff where worried about something and supported thereafter.

The placement plan was named as the location for all such safety and response work in safeguarding but whilst the areas of attention were being identified they were not necessarily translating into direct work plans for the short or long term. There was evidence of the management and staff meeting with other professionals appropriately to have professional or strategy meetings.

The policy on protected disclosures was contained within the policy, was well developed and known by the staff members who were part of this inspection process.

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

There was a briefly stated policy in place on positive behaviour support with the full detail of the policy contained in an appendix. The appendix included reference to what the approach should look in practice and the supporting theory base was also contained in the appendix.

The staff team were trained in the management of behaviour that challenges through the therapeutic crisis intervention, TCI, model and the team utilised this well to represent much of their intervention work with young people. Inspectors found that the TCI programme was very well supported and trained for within the organisation, with staff on the team trained and invested in its implementation and value for the young people in their care. The wider positive behaviour support model was represented as a three tiered pyramid starting with a trauma informed, positive approach to prevention and progress, moving though to responsive strategies and finally if required restrictive practices and sanctions. The base of the pyramid prevention and progress was not yet as well described or well represented on file overall. Whilst the team have the support of consultation monthly with two clinical specialists there was no specific training in a trauma informed approach to care. Following the inspection inspectors were informed of specialist training being completed, by senior staff in the first instance, in May 2023 in a psychotherapeutic approach to developmental trauma. The centre can then consider how the team are supported and trained in this model at both induction and throughout their employment.

As stated, the staff had access to specialist advice on a monthly basis, but inspectors saw and heard limited evidence of how this guided the direct work, in line with the model, with the young people. The records maintained of this did not contain the

detail of what was discussed and decided at these consultations, this had been a recurring finding by inspection. This level of detail was important to see for a number of reasons central to which would be tracking of progress and secondly the team had been through significant changes in discharges, admissions, location and personnel so required a period of restructuring around their work. The areas for young people most impacted were long gaps found by inspectors where there was limited of interventions in specific disabilities like autism, mental health, identity, social isolation, chronic school refusal and diet. It was a concern for inspectors that these were long standing issues and lacking a robust plan of action. The social work department involved stated that they were satisfied that every effort had been made to support these issues but were open to new information and initiatives.

Inspectors found that the team and the young people had been through a period of significant change, with two house moves in quick succession and many changes on the staff team including a difficult loss and the team were mindful of the upset and changes experienced by all. Inspectors recommend that a strategic focus now be placed on key working, addressing specifics in mental health, health, disability, safeguarding and education. That the pathway for identifying key working and approaches in line with needs and the model to be more specific, named, resourced, and tracked.

The behaviour support policy referenced the clinical team in guiding, directing, formulating advice and identifying training as needed. As stated above the practices generated from multidisciplinary team meeting were not possible to fully see in the manner intended in the policy. Inspectors acknowledge that the management had recently identified the gap in the knowledge and approach base to autism and related difficulties and had initiated some planned sessions with their psychologist on this area.

There was low evidence found of a significant event review mechanism although the policy contained a rated escalation process of incident review. There was a gap in evidence and findings flowing back to the team for learning and informing of plans. Inspectors could see that significant events were listed for discussion on the multidisciplinary team meeting but the outcomes of the discussions were not recorded and thereafter not reflected on the plans reviewed.

Inspectors found that there was compliance with the policy in key areas related to daily planning, a focus on staff as positive role models and in the recording of positive reinforcement through rewards. The staff talked about positive role modelling with the young people as a tool and the young people came across as displaying a high level of openness to connect and communicate with staff and the staff in turn evidenced a high and positive availability to them.

There was a policy on restrictive practices that contained good information and inspectors found that the team should review this policy together as a group to discuss their shared understanding of it and how its implemented in the centre. The social care manager used a restrictive practice risk assessment tool and had spoken to the young people about individual restrictive practices, and it was clear that the young people were told about the reasons for certain rules and the reasons for certain restrictive practices. The use of restraint was understood as a restrictive practice and there had been no use of restraint listed in the preceding twelve months. Inspectors noted a conflict related to the use of restraint between the content of a risk assessment and an ICSP and requested that the management seek a medical opinion ideally in relation to this matter. The centre manager agreed to initiate appropriate action to clarify this.

The organisations quality assurance manager completed an audit of Theme 3 in the third week of January 2023, initial findings differed from inspectors in the examination of interventions for areas of vulnerability and for tailored key working responses. The behaviour support policy suite contained reference to gaining service user feedback and this had not been implemented as yet by the quality assurance team for this centre, it would be good for the team to hear back from young people, professionals and families where possible. Two young people had moved into independent living towards the end of 2022.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 3.1** **Standard 3.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre management and senior management must ensure that there are pathways for review of child protection reporting trends and learning taken from same to advise staff practice.
- The registered proprietor and senior management team must implement their intended 'Child Safeguarding Training Strategy inclusive of accessing, delivery, monitoring, evaluating'. All types of mandatory training related to this strategy must be listed on the training schedule.

- The centre management must implement a strategic plan inclusive of improvements to the knowledge base of staff to strengthen key working addressing specifics in mental health, health, disability, safeguarding and education.
- The centre management and staff must ensure that they maintain good quality minutes and clear actions from the multidisciplinary team meeting that are thereafter tracked and resourced appropriately.
- The senior management team must ensure that critical incidents are subject to review and feedback to the team to help inform ongoing practice.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

There was evidence across the young people's files of them being taken to their appointments with GP's, dentists, opticians and other health professionals. Hospital appointments were followed up and specialist requirements identified for young people like orthodontics were well managed. When new admissions took place they were brought to their GP or to a new GP for an initial medical review. A recent admission had a GP visit and the medication they required completed within days of admission and the young person had noted the benefit of this to their social worker.

The young people were supported with accessing counselling or having access to sessions with the organisation's consultant psychiatrist where they wished to do so. There was positive feedback from the social workers on the teams linking to young people's previous and ongoing support groups and support professionals, such as youth groups and youth workers. There were referrals made and funding approved for clinical assessment completed by the relevant social workers, for one the report had been provided to the centre and one assessment was upcoming. A social worker stated that the report provided was to inform the educational setting and the management agreed that it was their intention to integrate relevant advice and information from this into their work also. Attendance at child and adolescent mental health services, CAMHS, was supported and promoted where possible although appointment refusal was an ongoing area of concern for the team.

The placement plan structure did not robustly capture the picture over time of the dietary, disability, general medical and other related areas of health. The health

sections on the file did not contain all the relevant information on the young people that referred to their physical and mental health and disabilities. There was health information recorded in the contacts section and inspectors found that these would be better co-ordinated and organised for the health section.

At the last inspection in March of 2022 diet and health was an area arising for the attention at the centre, as was acknowledged by management. Despite some reference points inspectors could not see a cohesive approach identified for this as either an individualised strategy or a whole centre initiative. The centre team were very alert to young people's rights and sensitive to young people's views on discrimination whilst trying to meet potential health risks and these were not in balance at the time of this inspection. The daily logs did not note foods actually cooked and consumed by all the young people nor if this was in line with the meal plans created at the young people's meetings, so there was limited opportunity to track measurable outcomes on a balanced diet. The team must seek suitable advice to help inform incremental positive healthy living changes at the centre.

There was some indication on the records at the centre of the emergence of some self-harming behaviours and members of the team had previously trained in the national suicide awareness programmes of Safe Talk and ASIST. With the numbers of changes in staff the management should audit who has this training and promote staff to complete as part of complementary training for the role. Inspectors noted also that management meeting actions had identified that ligature cutters would be introduced at the centre, there was no time frame as yet for that. The team must be briefed in their use once in place.

The team had trained in first aid and medicines administration and there was a medicines management policy in place which stated that all staff will be medicines trained and that this will be thereafter be reviewed through an annual competency review. The annual competency review aspect of the policy had not been implemented as yet and must be if this is the company procedure.

Compliance with Regulation	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required	**None identified**

standard	

Actions required

- The centre management and staff must ensure that they maintain good co-ordinated health sections on the files.
- The centre management and senior management must investigate a healthy living approach within the centre and how this can be promoted and supported.
- The senior management team must ensure that the annual review of medication administration and medication management systems is implemented.

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 organisation had a workforce planning group in place, they met weekly and the regional manager for the centre attended this group. The group had co-ordinated the supports in place for staff and shared information related to these to the staff. There had been an expansion of the company structure to include additional roles such as the dedicated regional manager post and improved tracking of the provision of supervision to management and staff. Staff identified that previous issues had been responded to and brought to a conclusion. They further named that this included learning and that they would feel empowered and safe to raise concerns should they see a need. The team had been made aware again of the code of conduct as well as the policy on protected disclosures, the code of conduct was available in both the main policy document and in the employee handbook.

New initiatives and incentives for staff were being considered for 2023 geared to reducing sick leave. The availability of flexible working and reduced hours contracts have been part of the staff incentives for a number of years. At the time of the announcing of this inspection there were four full time contracts, of whom two were the social care manager and the deputy manager, and an additional eight staff on hours ranging from 22.5 to 30 per week, this provided in combination eight whole time equivalents of staff in order to comply with the relevant staffing requirements.

These contracts were all agreed at the request or application of the staff themselves and was a positive factor for them. During the inspection it was made known that one of the two full time staff would be moving post and another potentially reducing their hours somewhat, the outcome in the short term could be all social care staff outside management on reduced hours contracts. The centre must confirm their ongoing current staff numbers and contracted hours in response to this report.

The social care manager had been tracking staff changes during 2022 but inspectors found in comparing lists provided that many changes had occurred in a way that at times was difficult for the manager to track fully. A review of the rosters highlighted that the staff cover was regularly but not always the three required daily to meet the needs of the young people and that this was often challenged and required last minute planning and flexibility from staff. The manager included staffing on their risk register but the scoring and escalation procedures of this risk register required additional work to be clear and in line with the intended structure. This was an issue identified in the action plan for the last inspection in 2022 and remains an area requiring attention. There was no formal head office response to this risk register entry included in the contingencies and controls, this must be provided to evidence governance and oversight of risks.

A plan will be required regarding staffing to clarify persons in post, hours contracted and initiatives to reduce the impact of this on the three young people. The social workers and social work team leader interviewed for this inspection noted the numbers of staff as an area for attention, although all were happy with the level of competencies and quality of communication from a broad range of staff at the centre. One social worker identified that their young person had key people that they were forming relationships with and it was their hope that those staff would be on duty regularly and available to engage in the same positive manner they have to date.

Workforce planning has to take account of the need to act to assess and address impacts on rostering, work load on management and impact on children for the people management strategy for this centre. There were no social care leader level staff identified on the staff team despite actions from management meeting records in November 2022 stating that there will be three social care leader staff per house. A list of three social care staff qualified and experienced to social care leader level was provided to inspectors, currently this post does not have a specific job description or contract structure.

Inspectors found that staff were non-compliant with signing to a very significant degree with evidence also of copy and paste on some plans and items misfiled on the day of the inspection. This must be addressed further with the team. The staff stated that they were able to attend training and take leave and that the staffing levels were

up to three persons on duty on a regular basis. The team had access to a structured on call system to utilise for out of hours support and advice.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must implement the correct scoring and escalation process on their risk register in line with the intended structure where it relates to all areas including staffing.
- The centre management must implement a programme related to good file management and report writing procedures in order to eliminate copy and paste and improve signing.
- The registered proprietor and senior management team must provide a plan of action and must ensure that there is an effective governance response to the balance of staffing numbers and hours.
- The registered proprietor and senior management team must provide the intended social care leader posts for this centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre management and senior management must ensure that there are pathways for review of child protection reporting trends and learning taken from same to advise staff practice.	Centre management will ensure that there are pathways for review of child protection reporting trends by ensuring these are discussed at multidisciplinary team meetings to advise staff practice. Discussions will be held with the team in relation to the content included in CPWRF's and ensuring this content is sufficient to highlight the concerns relating to child protection concerns. Further review of the thresholds of concern will also be discussed to ensure learning from previous reports. To be completed by April 28th '23.	Child protection reporting trends will be discussed with the team in upcoming team meetings and as they occur in the future. Child protection concerns and trends will be discussed at monthly senior management meetings and feedback, follow up and direction provided where necessary.
	The registered proprietor and senior management team must implement their intended 'Child Safeguarding Training Strategy inclusive of accessing,	The registered proprietor and senior managers will implement their intended child safeguarding training strategy via the yearly training needs analysis each	The child safeguarding training strategy will be reviewed annually by the senior management team. A mandatory training record is disseminated to the centre

	delivery, monitoring, evaluating'. All types of mandatory training related to this strategy must be listed on the training schedule. The centre management must implement a strategic plan inclusive of improvements to the knowledge base of staff to strengthen key working addressing specifics in mental health, health, disability, safeguarding and education.	November. All mandatory training is recorded on the training schedule. A record is also kept on non-mandatory training undertaken. The process for sourcing specific health needs and training regarding same had commenced at the time of the inspection. LGBTQIA training had been arranged and occurred on March 1st 23. Training on Autism had also been in development at the time of the inspection and following significant research conducted, this is now scheduled for March 28th 23. Other specific identified needs will be resourced and implemented with the YP and staff will be implemented to resource this. Centre management have discussed with the clinical team how to strengthen the recording, evidencing, and implementation of actions that can then be tracked and resourced appropriately, across placement plans and via key working.	manager each November outlining the mandatory training schedule for each staff member. The centre manager will ensure that the needs of each young person are reviewed in their monthly MDTM's whereby areas of vulnerability and development for each young person are identified and recorded. Placement plans, overseen by the clinical team, will ensure that areas for specific focus in addition to other identified needs, and identified key working goals, are reflected in the placement plans. Any training identified to meet the needs of the young people will be implemented accordingly.

	The centre management and staff must ensure that they maintain good quality minutes and clear actions from the multidisciplinary team meeting that are thereafter tracked and resourced appropriately. The senior management team must ensure that critical incidents are subject to review and feedback to the team to help inform ongoing practice.	Centre management and staff will ensure good quality minutes and clear actions from the multidisciplinary team meetings are effectively recorded. Agreed guidance and interventions will then and followed by the centre management, keyworkers and care team and regular oversight maintained by the centre management. The centre manager will ensure that patterns, trends, and analysis of critical incidents are discussed at team meetings. Critical incidents are discussed monthly at MDTM's and recorded on MDTM minutes. This ensures that patterns, trends, and analysis are reviewed to ensure best practice and to improve the care provided in the centre. Immediate and ongoing.	The centre management will review all multidisciplinary team meetings to ensure minutes are accurately recorded. These minutes are then shared with the clinical team who in turn will sign off on the minutes to ensure that all discussion points have been evidenced and recorded. The senior management team and centre manager to ensure that critical incidents are reviewed as part of the multidisciplinary team meeting framework on a monthly basis. The clinical team will liaise with the centre management to provide feedback on critical incidents and debriefing / PCR's will organised when and where required.
4	The centre management and staff must ensure that they maintain good co-ordinated health sections on the files.	Centre management will ensure that health sections on files are co-ordinated effectively. A review of the files will be completed by centre management and discussed with the care team to ensure all sections are reviewed with all team	Centre management will communicate via upcoming team meetings the reviewing of files and filing of documents. All new starters will be inducted in how to document, file and maintain good health sections. The centre manager will ensure

		members (inclusive of new starters on the team). To be completed by April 30th '23.	that regular robust review of files is undertaken.
	The centre management and senior management must investigate a healthy living approach within the centre and how this can be promoted and supported.	The centre management ensure a healthy living approach is maintained within the centre via the purchase of healthy foods and making all homemade meals as healthy as possible. Young people are encouraged to participate in menu planning and to utilise healthier cooking options such as an air fryer/slow cooker. This healthy living approach will be subject to regular discussion and review with the care team. Immediate and ongoing.	The centre management has recently purchased a number of cook books and cooking equipment to promote a healthier approach to living. Centre management and senior management will periodically review the healthy living approach and strategies within the centre through centre audits and team meetings.
	The senior management team must ensure that the annual review of medication administration and medication management systems is implemented.	The annual review of medication administration and medication management with the staff will be completed by April 30th '23. This allows time to complete this process with all current staff as well as time for new starters to be fully inducted and informed.	The senior management will ensure that the centre manager reviews the medication administration and management systems with all staff annually to ensure that all staff are compliant with annual reviews of medication.

6	The centre manager must implement the correct scoring and escalation process on their risk register in line with the intended structure where it relates to all areas including staffing.	A review of the risk management framework is currently underway to ensure all risks are appropriately identified. Once established the centre manager will ensure that the correct scoring and escalation process on the risk register in line with the structure where it relates to all areas including staffing. To be completed by March 31st, 2023	Once this review is completed, the centre manager will ensure the risk management framework is applied consistently across all areas of risk management inclusive of staffing. Centre management will then ensure the escalation process is followed for all risks.
	The centre management must implement a programme related to good file management and report writing procedures in order to eliminate copy and paste and improve signing.	Centre management will ensure that good file management takes place. The centre manager will maintain regular and appropriate oversight of care files. Immediate and ongoing. This will be discussed with the care team by March 28th 2023.	The centre management will ensure that all files are subject to a robust review on a regular basis to ensure that any deficits are identified and rectified in a timely manner. Files are also subject to review by senior management for the purposes of auditing
	The registered proprietor and senior management team must provide a plan of action and must ensure that there is an effective governance response to the balance of staffing numbers and hours.	Since inspection two new candidates have accepted full time positions within the centre with another member of staff accepting a transfer to the centre on a full time basis. Staffing requirements will continue to be reviewed on an ongoing basis. Immediate and ongoing.	Senior management will ensure that organisational workforce planning, and recruitment will remain active and ongoing to ensure regular staff are available to ensure consistency of care for the young people.

	The registered proprietor and senior management team must provide the intended social care leader posts for this centre.	At the time of the inspection three staff had been identified and qualified to social care leader level. All three staff are now named on the centre staff census as such and made known to inspectors.	Senior management will ensure workforce planning includes monitoring of staffing at all grades and ensure relevant details are included in staff census reports.