An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 028

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Traveller Families Care**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced Themed Inspection**
Date of inspection:	**01st, 02nd, and 07th September 2022**
Registration Status:	**Registered from 05th December 2022 to 05th December 2025**
Inspection Team:	**Linda Mc Guinness** **Sinead Tierney** **Janice Ryan**
Date Report Issued:	**16th February 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 10th of October 2000. The centre changed its statement of purpose in 2016 and was granted their first registration under the new purpose and function in the same year. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from 05th December 2019 to 05th December 2022.

The centre was registered as a multioccupancy service to accommodate six young people of all genders from age thirteen to seventeen years on admission on a short to medium term basis. It provided care and accommodation for separated children seeking asylum (SCSA) in Ireland. Their model of care was described as a needs-based model that was implemented through the application of Maslow's Hierarchy of Needs that included psychological, safety and security, belonging and love, self-esteem, and self-actualisation. There were six 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
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

At the time of this inspection the centre was registered from the 05th of December 2019 to the 05th of December 2022. This is a draft report and the decision regarding the continued registration status of the centre is pending.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 16th September 2022. 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 28th September 2022. Following a period of discussion negotiation with Tulsa increases in staffing were agreed. The responses to the CAPA were deemed to be 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: 028 without attached conditions from the 05th of December 2022 to the 05th of December 2025 pursuant to Part VIII, 1991 Child Care Act.

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.

At the time of inspection, there were six young people were living in the centre. Inspectors found that only two of the young people had an up-to-date care plan on file. Inspectors spoke with the social work team leader for the SCSA service, and they explained that as a result of undue pressures on the department managing young people seeking asylum, the centre were being sent minutes of child in care review meetings. This was evident on care files where three files had minutes of child in care review meetings. However, in one case the centre was reliant on their own record of the meeting to facilitate placement planning as they had not yet received Tulsa minutes. There was no formal escalation process in place to ensure that statutory care plans were provided in line with regulations.

Inspectors found that while there were some short delays in convening child in care review meetings there was evidence the centre contacted the social work department to ensure appropriate follow up. It was evident from centre records, staff interviews and speaking with young people that they were provided with opportunities to input into their child in care reviews and that their views were considered.

Inspectors observed warm caring relationships between young people and staff members during the visit to the centre. The social workers or social work team leader for all six people were interviewed by the inspectors. They confirmed a collaborative approach to the care of young people and stated that the centre provided excellent care from a consistent and stable team. From the outset of placements, inspectors found that the team had a strong focus on assisting young people to integrate into Irish society and they provided an excellent orientation to the local area, transport links and community supports. In line with the stated model of care, there was evidence that there were individualised programmes in place to alleviate vulnerabilities that separated young people seeking asylum might face. Inspectors found significant evidence that young people were supported with their education and their religious and cultural needs. Staff received and utilised the supplementary training provided by the centre to proactively support young people.

Inspectors found up to date placements plans for each young person that identified needs and specified actions to meet the goals within a clear timeframe. There was evidence that focused key working was undertaken proactively by staff members and it was overseen by centre management. The team used a variety of tools and resources to engage young people and a review of team meeting minutes demonstrated that discussions took place in relation to placement planning. There was much evidence that opportunities were provided for young people to input into their plans in an age-appropriate way and they confirmed this in discussions with inspectors. The care files reviewed contained appropriate and detailed information of the extensive work staff completed with young people.

While there was evidence of accountability for work through a case manager system this was negatively impacted by the lack of availability of social care leaders in the centre. Staff had declined to continue completing this task as it was outside their core responsibilities and they were not remunerated for it. This was related to a wider pay dispute and staffing is further discussed under theme 6 of this report. The social care manager assumed the case manager role but this created an additional workload and management support was limited in the centre. This is further discussed under theme 5 of this report.

Each social worker or social work team leader confirmed to inspectors that they received progress reports from the centre on a monthly basis and that they were in regular communication with the manager or allocated keyworkers to facilitate planning. Where possible the team communicated with and involved families.

Each young person had an absence management plan that was regularly reviewed and usually signed off as not requiring any changes. This system was generally effective but inspectors recommend additional oversight to ensure that no required updates are missed as was the case in one file reviewed.

Where it was deemed necessary and appropriate, and in consultation with the social work department, the team sourced the support of specialist services to assess and respond to individual needs. A community-based counselling, medical and legal support service was available to young people who had experienced trauma. Where this was unavailable or waiting lists were too long, the team advocated strongly to ensure that young people had access to alternative supports.

Each young person had an individual crisis support plan in line with the stated model of behaviour management. Some of these had not yet been updated to the most

recent version of the programme and the centre manager confirmed that this was planned as soon as the whole team were trained in version 7. Also, inspectors found that a version of physical intervention was permissible in the plans, however it was unlikely that this could be employed given past trauma of young people and staffing levels in the centre. The plans should be updated to reflect this.

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

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

Actions required

- The registered provider must ensure that there is appropriate escalation within the social work department when care plans are not provided in line with regulations following statutory child in care review meetings.
- The registered provider must ensure that the most up to date version of the behaviour management programme is implemented fully, and that the use of restraint is reconsidered given the staffing levels and unknown information about young people.

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.

There was a governance structure in place that saw the centre manager report to the director of service who in turn reported to a board of management. The governance structure set out internal and external management roles and governance responsibilities. Inspectors also found that there was a service level agreement in place with the Child and Family Agency and meetings took place annually.

A team of social care workers reported to the centre manager who was the named person in charge with overall responsibility for delivery of the service. The manager was supported in their role for 11 hours each week by a deputy manager who also worked 25 hours weekly covering an overnight shift in the centre. There were no social care leaders in the service to assume extra responsibilities and support the management function. From interviews with social workers, staff, and management, and analysis of centre records inspectors found that this internal management structure was not appropriate to the size and purpose and function of the residential centre. The centre was providing care to six young people, and the daily routines and planning for all aspects of their care in a rural location, required a full-time deputy manager and some staff at social care leader level to ensure its effective delivery. Staffing is discussed further under standard 6.1 of this report.

There was no delegation record to list areas of responsibility and tasks for the deputy manager or a record of key decisions made in the absence of the centre manager and this must be implemented. The centre manager stated that while the deputy manager worked day shifts in their absence, they did not delegate all their managerial responsibilities when taking planned leave.

The organisational structure identified the director of service as being responsible for compliance with the standards and regulations. Inspectors found they were fully aware of all aspects of the running of the centre and visited several times per week. Young people and staff were familiar with them and said they were always available

and very supportive. Notwithstanding this, inspectors found that the role of the director was more of a hands-on operational role rather than clearly holding oversight and compliance responsibilities. This arrangement was not robust enough to oversee the delivery of care, the review of operational policies and procedures and assessment of compliance with the relevant regulations and national standards.

Inspectors found that the system of auditing in place did not demonstrate an analysis of compliance which in turn did not feed into a culture of learning, quality, and service improvement. For example, staff in interview were generally aware of policies and procedures; however, there was a lack of awareness of aspects of Children First: National Guidance for the Protection and Welfare of Children, 2017 including the role of the designated liaison person and the centre's child safeguarding statement. This was not highlighted by any internal auditing processes. It should be noted that an inspection of another centre in this organisation made a similar finding in 2021 that has not yet been fully implemented across the service. The registered provider must ensure that actions arising from inspections are implemented across the service in a timely manner.

The director of service audit report covering the period January to April 2022 was reviewed during inspection. The report was 61 pages long however it included large sections of narrative on progress for young people and other information which was duplication of other reports already provided. It did not, for example, highlight a delay in review of policies and procedures that was outstanding, review quality of supervision or assess compliance with mandatory training. Other audits provided for inspection purposes were self-audits by the centre manager or staff members which included key working, health and safety, medication and first aid. The director's audits of the service did not evidence quality assurance or validation of these self-audits by the centre manager. For example, the health and safety audits detailed lists of maintenance work completed, but it did not reference if the health and safety statement was up to date and signed, or it did not include accidents or assess adherence with the health and safety policy in general.

Also, the information provided on the Garda vetting database was not accurate at the time of inspection and one personnel file reviewed did not contain a qualification parchment. These issues were not identified through internal or external auditing. While it was clear the director was hands-on and involved in the centre, they must review their role to ensure that their oversight and auditing includes compliance with national standards and regulations as well as staff knowledge of key legislation and centre policies.

Inspectors found that that the director attended team meetings regularly and visited the centre frequently on an ad-hoc basis. There were no formal records maintained of these external management visits to the centre therefore inspectors could not ascertain fully how they fulfilled their governance responsibilities.

There was no date on the suite of policies and procedures provided during inspection, however inspectors were informed that they were under review at the team meetings with the input of the director, centre manager and team. These policies were due formal review and sign off that was outstanding for some time and this was highlighted in management meetings. For example, the recruitment and selection policy was not in line with best practice or the requirements of the department of health circular on the recruitment of staff to children's residential centres, 1994. For example, the policy stated, *'other selection methods may be employed where appropriate, for example reference checking'*. This is an absolute requirement as is a robust interview and selection process, a process for garda vetting and police checks, and verification of qualifications. These were not set out in the policy.

Policy review was stated as being the responsibility of the director of service however, due to their significant direct involvement in the centre, their capacity to attend to these responsibilities was reduced. This must be reviewed in consultation with the board of management.

There was a risk management framework in place that consisted of a scoring matrix, individual risk assessments, an individual log for each young person and a centre risk register. Inspectors found that while the matrix was a useful tool and was understood by staff, it required review to ensure that risks were categorised correctly. Also, some risks identified on care files were general and not specific or applicable to individual young people and should be maintained on the centre register unless deemed relevant to them.

In respect of some organisational risks, inspectors found that the entries were a description and analysis of the risk but did not follow up with appropriate control measure to manage the risk and mitigate against negative impact. There was very limited evidence or substantial discussions about managing risk at board meetings.

Inspectors found that significant event review meetings took place in line with policy and that complaints, child protection and significant events were reviewed and monitored at this forum. There was evidence of good support to staff, debriefing following incidents, identification of key learnings and analysis of effective and

ineffective strategies to reduce risk. This process could be improved with a stronger connection to individual crisis support plans and individual absence management plans as these was not evident in the records reviewed.

Supervision of the centre manager should form part of the leadership and governance system in the centre. While supervision was taking place regularly and the manager described it as supportive, the records reviewed were duplicates of other reports created in the centre and did not contain discussions of key areas of responsibility or specify actions requiring attention.

Inspectors found that reports were created for the board of management from each service in the organisation and were sent in advance of the meetings. Inspectors found that the system in place was not compliant with the principles of General Data Protection Regulations, 2018 (GDPR). These reports were extremely detailed, contained identifiable information of young people including full names and dates of birth and other personal information. The organisational structure set out two functions of the board which were namely, to provide strategic guidance and oversee the organisations management, and secondly, they had responsibility for fulfilment of the company's ethos and legal accountability for its operations. The provision of the information above to the board was excessive and not relevant to these functions. Further, the information was not kept safe and secure as it sent to personal email accounts with no identified procedure to guide the retention and deletion of this data.

Overall, it is the finding of inspectors at this time that the leadership, governance, and management arrangements are not robust enough to sustain a child-centred, safe, and effective service. Improvements are required to develop a culture of oversight and continuous improvement. Therefore, the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5.

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

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

Actions required

- The registered providers in consultation with Tusla as the funding body must ensure that the internal management structure (including deputy social care manager and social care leaders) is appropriate to the size and purpose and function of the centre.
- The registered provider must devise and implement robust auditing processes to ensure effective oversight of care practices, operational policies and compliance with relevant regulations and national standards.
- The registered provider must ensure that actions arising from inspections processes are implemented in a timely manner.
- The registered provider must ensure that the required review of policies and procedures is completed, and policies are updated to bring them in line with legislative requirements and best practice.
- The registered provider must ensure that the risk management framework is revised taking account the findings of this inspection.
- The registered provider must ensure that the organisation is compliant with GDPR legislation, 2018. They must consult with the board of management and ensure that excessive, non-relevant information outside of its specified purpose is not provided to other persons.
- The registered provider must ensure that young people's information is kept safe and secure in line with the requirements of the legislation.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found that planning and management of the workforce was supported by policies relating to induction, training, supervision, and appraisals. The review of centre policies must also include expansion to include robust recruitment and retention policies.

While workforce planning was discussed at some level in team meetings and at management level it was not sufficient to monitor the ongoing operation of the centre. It did not identify concrete actions or decisions when deficits were noted to ensure the delivery of safe and effective care. While the director of service indicated it was on the agenda at an upcoming service level agreement meeting, there was a lack of evidence to date that definitive action was taken at senior management and board of management level to escalate staffing deficits for priority action.

The staff team comprised of the manager, part-time deputy as outlined above, as well as 10.9 wholetime equivalent posts (which included some staff members on banded hours contracts). While inspectors found that the team had the experience and competencies to meet the needs of young people, they did not find that staffing levels were adequate having regard to the number of children residing in the centre and the nature of their needs. The centre implemented a daily roster pattern of two sleep over shifts and one day shift from 10am to 10pm (although there were several occasions the day shift finished at 8pm or 9pm).

Inspectors' analysis found that not enough staff were available to meet the required rostering arrangements and relief staff were consistently covering core lines on the rota. The rota was not configured so that appointments, education and curfews of young people could be managed safely. From inspection interviews and review of rosters, inspectors found that there were many occasions where the day to day running of the centre depended on management filling gaps on the rota or stepping in to facilitate daily routines. Staff members finished shifts at 10pm which was too early to facilitate young people to return to the centre at their stated curfew times and

still have cover in the centre. There were occasions where there was not enough staff cover to implement the required roster, and only part of a shift was covered or only two people were rostered. While this was acknowledged as Covid 19 contingency measure this also happened outside of Covid positive cases. Inspectors found also that relief staff were scheduled to cover core lines on the roster which then decreased the number of relief available to cover gaps. There was not sufficient relief staff available to cover planned and unplanned leave. Records reviewed during the inspection visit showed that staff were frustrated at not having enough time to attend to administrative tasks. The deficits in staffing were also highlighted in inspection interviews with staff, social work teams and management.

Inspectors found that due to historical practices and inadequate staffing, the centre was reliant on an unqualified ancillary staff member to attend to duties that were the responsibility of the social care team. This person was receiving professional social care supervision, had attended mandatory and supplementary training, attended team meetings, and was involved in planning for young people. They had also accrued time owed in lieu having attended to duties outside their normal function. While it is acknowledged that this person was a long-standing employee and was an important member of staff, the registered provider must ensure that only persons employed as social care workers fulfil that function in all circumstances.

Issues outside the centre relating to pay and terms and conditions had contributed to low staff morale and frustration. This was highlighted on the risk register. Inspectors found no evidence that this impacted negatively on the care of young people. Six of the staff team had worked in the centre more than ten years and it was evident that this provided a culture of stability and consistency, however there were no evidence of discussions or specific arrangements in place to promote staff retention. Management meetings or supervision of the manager did not evidence discussions on how to support staff that may be feeling under appreciated.

The centre manager and deputy manager shared on-call at evenings and weekends on a week on, week off basis and the director was available to fill any gaps or provide extra support. An enhanced internal management structure would facilitate a more sustainable on call provision.

Social workers and the social work team leader who spoke to inspectors commented positively on the skills of the staff team and the positive relationships they built with young people.

While the centre demonstrated positive care practices to meet the identified needs of young people, it is the finding of inspectors that due to the insufficient numbers of staff to meet the needs of the young people that the centre is not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7.

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

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

Actions required

- The registered provider must ensure that the review of centre policies must also include expansion to include robust recruitment and retention policies.
- The registered providers in consultation with Tusla as the funding body must ensure that the centre has sufficient numbers of permanent and relief staff members having regard to the number of young people and the nature of their needs.
- The registered provider must ensure that only persons employed as social care workers fulfil that role in all circumstances.
- The registered provider must ensure that there is evidence of arrangements in place to promote staff retention.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered provider must ensure that there is appropriate escalation within the social work department when care plans are not provided in line with regulations following statutory child in care review meetings. The registered provider must ensure that the most up to date version of the behaviour management programme is implemented fully, and that the use of restraint is reconsidered given the staffing levels and unknown information about young people.	An escalation policy is currently being implemented and will be in place by 31st October 2022. ICSP's have been updated to remove the standing hold to reflect staffing levels and the young people's backgrounds.	Monthly managers meeting will include a section to note any escalations that are required in relation to care plans, meeting minutes, legal documentation and ICSP's. The Director of Services will ensure through the auditing process that all young people's files are up to date and that ICSPs are in line with staffing levels and based on information known about the young people.
5	The registered providers in consultation with Tusla as the funding body must ensure that	A meeting took with Tusla and the centre now has a fulltime deputy post and two extra social care leader posts.	Following meetings, the registered provider will continue communication with Tusla to ensure that staffing levels are maintained

	the internal management structure (including deputy social care manager and social care leaders) is appropriate to the size and purpose and function of the centre.		and funded as appropriate. In addition, the registered provider will continue to review employee retention strategies in order to retain their staff teams.
	The registered provider must devise and implement robust auditing processes to ensure effective oversight of care practices, operational policies and compliance with relevant regulations and national standards.	A new auditing tool based on the National Standards and the organisations policies and procedures has been implemented which includes actions identified and assigned timeframes. This process is currently underway for the second quarter.	Training has been provided to management team in respect of auditing processes.
	The registered provider must ensure that actions arising from inspections processes are implemented in a timely manner.	In response to the previous inspection report, child protection training has been completed with the team on the 28/09/2022 to refresh the team's knowledge with focus on the role of DLP and mandated reporting.	A schedule of auditing by the Director of Services is in place. This schedule will also include verification of actions completed where areas for improvement have been identified thorough inspection process.

	The registered provider must ensure that the required review of policies and procedures is completed, and policies are updated to bring them in line with legislative requirements and best practice.	A review of the policies and procedures is underway and will be completed by December 2022. The staff team will continue to review same at team meetings.	There will be ongoing review in team and management meeting and an annual review of policies and procedures.
	The registered provider must ensure that the risk management framework is revised taking account the findings of this inspection.	The risk management framework has been revised following our inspection. It will be implemented following scheduled team training on the 12/10/22	A new section has been added to the monthly manager's meetings to ensure effective oversight of actions requiring attention.
	The registered provider must ensure that the organisation is compliant with GDPR legislation, 2018. They must consult with the board of management and ensure that excessive, non-relevant information outside of its specified purpose is not provided to other persons.	Effective immediately. The Board of Management are given a verbal handover and update on all the organisations services.	A review of risk management will occur annually with the team to ensure knowledge of the framework and responsive service provision is in place. The registered provider will ensure that the function of the Board of Management is reflected in the meeting minutes.

	The registered provider must ensure that young people's information is kept safe and secure in line with the requirements of the legislation.	Effective immediately the Board of Management no longer receive copies of any reports pertaining to the young people to ensure all young people's information is being kept safe and secure.	To protect all young person's sensitive and identifiable information, relevant reports will be discussed at Board of Management meetings rather than being sent to personal email addresses.
6	The registered provider must ensure that the review of centre policies must also include expansion to include robust recruitment and retention policies. The registered providers in consultation with Tusla as the funding body must ensure that the centre has sufficient numbers of permanent and relief staff members having regard to the number of young people and the nature of their needs. The registered provider must ensure that only persons employed as social care workers	A review of the policies and procedures is underway and will be completed by December 2022 which will include a robust recruitment and retention policy. The staff team will continue to review same at team meetings. Funding was secured from Tusla for two extra fulltime social care worker posts. Recruitment ongoing. Implemented immediately, only staff members employed as social care workers	Policies and procedures will be reviewed annually, or sooner, if required by the Director of Services as part of their oversight function. Following the meeting with Tusla, the registered provider will continue communication to ensure that staffing levels are funded and maintained in line with the young people's needs. The registered provider will review practices in the centre, as part of their auditing

	fulfil that role in all circumstances. The registered provider must ensure that there is evidence of arrangements in place to promote staff retention.	are fulfilling the role with the young people living in the centre. A recruitment and retention policy is being developed and will be in effect by December 2022.	process, to ensure that all employees are completing tasks in line with their roles. Centre Management and the Director of Services will review the staffing levels in the centre on an ongoing basis to ensure that there are sufficient levels and that a stable team is in place. The registered provider will continue to provide team building days and ensure staff receive training as part of their continuous professional development.