An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 065

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Curam Nua Ltd**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Announced Inspection**
Date of inspection:	**07th, 08th & 09th March 2022**
Registration Status:	**Registered from 30th April 2021 to 30th April 2024**
Inspection Team:	**Sinead Tierney** **Lorna Wogan**
Date Report Issued:	**26th May 2022**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 30th of April 2015. 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 during the inspection with attached conditions under Part VIII Article 61 (6), (a) (i) of the Child Care Act 1991 from the 30th of April 2021 to the 30th of April 2024. Following this inspection, it was the finding of the registration committee that the corrective actions were implemented, and the condition was removed from the registration of the centre.

The centre was registered as a dual occupancy service. It aimed to provide a medium-term programme of care to young people of both genders aged twelve to seventeen years on admission. Their model of care was described as the provision of residential care for children and young people using a *'blended theoretical and best practice approach*'. The model was underpinned by the theories and frameworks of a person-centred approach, attachment theory and attachment informed parenting, a resilience strengths-based approach and a trauma informed model of care. The engagement of children in outdoor pursuits was also a key component of the therapeutic programme of care in the centre. There were two young people living in the centre at the time of the inspection. The centre had been granted a derogation to the registration status for both young people as they were under twelve years of age on admission which was outside of the centre's statement of purpose.

1.2 Methodology

The inspector examined the following themes and standards:

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

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 11th of April 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 of April 2022. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The initial findings of the inspection were that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7. However subsequent to the inspection the registered provider took corrective action to address the issues identified and the inspectors are now satisfied that the centre is in compliance.

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: 065 without attached conditions from the 30th of April 2021 to the 30th of April 2024 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, two young people were living in the centre. Inspectors met with both young people, and they expressed that they were happy living in the centre and had plenty of opportunity to engage in activities and outdoor adventure. They spoke of times when they were not getting along with each other, and the staff team had supported them through this period. They identified team members they had strong relationships with and how they were supported in preparation for their child in care reviews (CICR). They also mentioned that they didn't like the turnover of staff and missed some staff that had recently left the centre.

The ethos of the centre to involve young people and families in planning was evident, both from a review of records and from speaking to the young people themselves. The relationships with parents, extended families and other key people in the lives of the young people was well established. Records, observations of practice and interviews demonstrated to inspectors that the team were committed to providing quality care to the young people. They placed a value on building and maintaining trusting relationships and had worked well with the young people through difficult periods of behaviours that challenge over the past 10 months.

Social workers for both young people were interviewed by inspectors. One social worker described how the young person had made great progress and their needs were being well met. Another social worker felt that the young person had made some good progress in recent months and that the team had a good understanding of their needs. A parent of one young person told the social worker that they were happy with how their child had settled into the centre and the arrangements in place to maintain their relationship.

There was evidence on file of staff preparing the young people for their review meetings and of supporting them to have their voice heard. Monthly CICR meetings had not taken place in line with national policy for one young person. The social worker informed inspectors this was due to the HSE cyber-attack. Minutes of reviews

were not held consistently on the care file and given that an up-to-date care plan was not on file for one young person, it is imperative that the centre outlines the expectations of receiving these in a timely manner to the supervising social workers.

One young person had an up-to-date care plan on file. The other young person did not have an up-to-date care plan on file and the only plan available was significantly outdated (February 2019). There was a lack of evidence that care plans or minutes of care plan review meetings had been requested. The supervising social worker confirmed to inspectors that they sent the current care plan dated February 2022 and previous CICR minutes to the centre post inspection. Given that CICR minutes nor care plans were on file for this young person, the inspectors were not fully assured that the placement plan was fully informed and based on their care plan.

Young people's placement plans were developed for a 3-month period and identified goals in areas such as family, health, and emotional wellbeing. The goals were broken down into named interventions, however inspectors found that these were not always tangible. Within the 3-month period there was a lack of planning in place to ensure that goals were achieved. Both the centre management and staff members interviewed acknowledged that the majority of work undertaken with young people was in response to their current needs and to behaviours such as assaults, threats, and property damage. The extent of this work was evident and also included teaching young people boundaries and providing significant educational support. Whilst the inspectors appreciate that the team responded to young people's current and emerging needs and behaviours, there must be a balance in relation to completing the developmental work required. The centre had recently developed a structure to mitigate this gap in planning with the development of a keyworking schedule. This however had not been introduced at the time of inspection.

Other documents in place to support placement planning included individual crisis support plans (ICSP), behaviour support strategy documents and absence management plans. Inspectors found that these plans on file were not current or up to date plans for young people. The centre manager provided updated plans post inspection and whilst these were more current that those on file, they remained outdated. For example, one young person's ICSP was dated November 2021 however a serious significant event notification for January 2022 recommended it be updated. Based on the date on the plan, this had not occurred. Additionally, the absence management plan was not individualised and did not provide a current picture of the young person's situation.

Both young people had opportunities to engage with specialist supports relevant to their needs. A specialist who recently engaged with one young person noted that they were a happier and healthier child since they last met. One young person chose not to attend scheduled appointments therefore the team were provided with support, information, and guidance from the specialist in the belief this would ultimately benefit the young person. The social worker for this young person felt that the benefits of this support were evident in recent months. They also felt that the opportunity for outdoor learning and activities provided by the centre's outdoor pursuits instructor was beneficial to their overall emotional wellbeing.

There was evidence of communication with social workers and regular visits to the young people had occurred. Both management and staff interviewed felt that communication was more effective with one young person's social worker as the social worker for the second young person was not easily accessible. A young person had voiced their dissatisfaction with the level of contact from their social worker and this had been addressed and a plan put in place at a recent CICR. During interview with staff and discussion with the young person, they were not aware of what avenues external to the centre were available should they wish to complain about the quality of social work provision. The centre manager must ensure that both staff and young people are aware of Tusla's feedback and complaints system '*Tell Us*' and the Ombudsman for Children's Office should it be needed. Young people should be provided with this information in age-appropriate manner.

Compliance with Regulation	
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 centre manager must ensure that each child's care record is kept up to date and contains information as specified in the regulations and the national standards.

- The centre manager must ensure that goals named in placement plans are tangible and effective planning takes place to achieve these.
- The centre manager in conjunction with key workers must ensure that the ICSP, AMP and behaviour support strategy document for both young people is kept up to date to reflect their current needs and behaviour and appropriate interventions by staff.
- The centre manager must increase the awareness of both young people and team members on external complaints systems available such as Tusla's '*Tell Us*' and the Ombudsman for Children's Office.

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.

The centre manager was the named person in charge with overall accountability and responsibility for delivery of the service. They were in post for over one year and had extensive experience of working with children and families. Inspectors found the manager to be committed to achieving positives outcomes for young people. Social workers described good working relationships with the manager and stated that the management team had positive relationships with the young people and their families. They were available to them, attended planning meetings and provided timely updates on all issues relating to the care of young people. The staff members interviewed described the manager as a calming influence, attuned to the impact of trauma for young people and supportive.

At the time of the inspection the registered provider had applied for a contract with the Child and Family Agency and was awaiting the outcome of the process.

Following an inspection of the centre in October 2021, the registered provider was required to strengthen a number of practices and governance arrangements. Inspectors found that the registered provider alongside the management team had been proactive in addressing the required corrective actions. This included the setting up of a working group that resulted in a suite of updated policies and

procedures. The format and recording of management and governance meetings was improved and an auditing framework had been developed and had commenced. A recruitment drive to secure suitably qualified staff members was undertaken.

A newly developed auditing policy, framework and structure was in place together with the creation of two quality and governance officer roles. One role was part-time and held by a previous acting centre manager. The second role was held by a social care worker within the centre with 50 hours of their monthly contracted hours allocated to this role. The registered provider outlined to inspectors that the second role had a focus on the gathering of quantitative data in order for this data to be analysed by the part-time officer. Inspectors informed the registered provider that the responsibility for auditing the centre's compliance with regulations and standards and holding management to account could not sit with a social care worker and the structure as outlined must be adhered to.

The quality and governance officers had a schedule in place that aimed for three thematic audits to be completed by May 2022. This had commenced with the auditing of the centre against theme 2 of the National Standards for Children's Residential Centre, 2018 (HIQA). However, at the time of inspection this audit was not fully completed.

Following a review of management and governance meetings, there was evidence of ongoing discussions in relation to young people, staffing and contracts, recruitment, shift patterns and training. However, the review of significant events was not yet embedded in practice. Where a significant event was recorded as reviewed, there was insufficient information of any learning identified or changes to practice with young people. This was a similar pattern in the centre team meeting minutes whereby the learning from incidents was not recorded.

There was an internal management structure appropriate to the size and purpose of the centre. The manager was supported in their leadership role by a recently appointed deputy manager and two social care leaders. The centre manager was on extended leave in December 2021 and January 2022. During this time, their duties were delegated to an acting manager and the deputy manager. A delegation record was developed for the acting manager however there was no record currently in place for the deputy manager. The centre manager must develop a delegation record with the deputy manager and ensure that key decisions made in their absence are recorded.

As mentioned, the centre had recently updated the policies and procedures document with the support of a working group. The implementation of these policies had commenced with an interactive training workshop for staff covering themes 1 and 2 of the policy document. Staff interviewed by the inspectors described the policy training as very beneficial and further dates were planned for the coming months to ensure that all policies were covered with all staff. The registered provider must ensure this training is satisfactorily completed as staff did not demonstrate competency in their knowledge of centre's policies in their interviews with the inspectors. A review of the policies had been scheduled for June 2022. During review, the registered provider must ensure that the social media and internet use policy as required in a previous inspection is incorporated into the suite of policies. The child safeguarding policy references an IT, Email and Internet Usage policy however this policy is not contained within the document and must be developed. As the policies have been recently updated, there are a number of new practices that have not yet commenced within the centre. Inspectors highlighted these practices to the registered provider and efforts must be made to introduce them in a timely manner.

A policy led risk management framework was in place that utilised a risk rating system to ensure that risk was appropriately assessed and managed. Updated impact risk assessments were on file for both young people and these were found to be detailed and well thought out, with risks clearly identified and minimisation measures put in place. A corporate risk register was dated May 2021 and identified 5 risks. Inspectors found that the register was not up to date and was not used as a working document where new risks were registered as they arose.

In terms of individually assessing risks for young people, inspectors found that assessments were primarily based on activities and outdoor sports. Observations of practice and records evidenced that staff adhered and promoted the safety measures named in these assessments with young people. However, in interview staff were not confident that if a risk arose other than those already identified, they would be able to assess it and put measures in place to keep young people safe. This was evident when a situation arose where a young person was alone with one staff member overnight. The risk assessment was generic by design and did not name the actual risks associated with the situation or name practical measures to be followed to ensure safety.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the auditing framework schedule is adhered to and findings overseen by a suitably experienced person.
- The registered provider and the centre manager must embed the practice of reviewing significant events and ensure the learning from these reviews is recorded and shared with the wider team.
- The centre manager must develop a delegation record with the deputy manager and ensure that key decisions made in their absence are recorded.
- The registered provider must ensure that policy and procedure training is satisfactorily completed by all staff.
- The registered provider must ensure that a social media, IT, email and internet use policy is developed.
- The registered provider must ensure that the corporate risk register is kept up to date.
- The centre manager must ensure that all staff understand how to identify, assess and manage risks and these are appropriately recorded and not generic assessments.

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 centre had made good progress since the last inspection visit in October 2021 in relation to workforce planning and development. Management meeting minutes evidenced that recruitment and workforce planning had been proactive in recent months. A range of updated policies and procedures were in place to support this planning including a recruitment and staff retention policy. Supports available to staff included access to external supports, training and supervision. A policy led on-call system that included procedures for on-call at evenings and weekends was in place.

The inspection found whilst a staffing plan was in place and recruitment in progress, the centre did not have the sufficient numbers of staff. Three team members had left the centre in February 2022 and the team currently consisted of the centre manager, deputy manager, 2 social care leaders (SCL) and 4 social care workers (SCW). One of these social care workers was on extended leave. This meant that 5 core team members were in place. The registered provider operated another centre and as no young people were residing there, the other staff team were temporarily redeployed to ensure that adequate staffing levels were available to the young people. Although the team was not stable, records evidenced that the core team understood the young people very well and displayed a warmth and compassion to supporting them through difficult periods. Social workers described how the team created a nurturing and caring environment for the young people and key relationships had been formed.

Prior to the final inspection report being issued, the registered provider sent an updated staffing structure dated May 2022 that consisted of 3 SCL's and 6 SCW's. From a review of the new staffing structure, it was found that sufficient numbers of staff were now in place. However, the team held a mix of qualifications, and the registered provider must continue to make efforts to ensure that long term members of the team that are unqualified obtain a recognised qualification.

Following a review of a sample of personnel files, the inspectors found that the majority of required documents such as garda vetting, qualifications and references

were in place. Whilst an audit of personnel files in January 2022 highlighted that one member of the team's garda vetting was due for renewal as per the centre's policy inspectors found no evidence that a renewal had been applied for. Consequently, this staff members vetting remained outdated and must be applied for immediately.

Training was provided on an ongoing basis for team members, and this included recent training in understanding the impact of adverse childhood experiences and responding to children with complex needs. Some mandatory training was outdated, and this must be completed for all team members and management as soon as possible.

A review of supervision records evidenced that supervision was not taking place in line with the centre's policy. Whilst informal supervision as described in the centre's policy was frequent, it cannot be a substitute for structured and planned supervision. The centre managers supervision records were not formally written and held on file. The registered provider must provide the inspectors with a copy of the managers supervision records and ensure that future sessions are appropriately recorded and filed. The centre manager must ensure that supervision takes place as outlined in the centre's policy.

Whilst the centre demonstrated that some practices met the required standards, it was the initial finding of inspectors that due to the insufficient numbers of suitably qualified staff that the centre is not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7. However, this was subsequently addressed, and the centre is now deemed to be in compliance.

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

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

Actions required

- The registered provider must ensure that a sufficient number of suitably qualified staff members are employed to meet the needs of the young people.
- The centre manager must ensure that garda vetting renewals are completed immediately.
- The centre manager must ensure that outstanding mandatory training is planned for and completed in a timely manner.
- The registered provider must ensure that supervision takes place in line with the centre's policy and records are kept on file.

3. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that each child's care record is kept up to date and contains information as specified in the regulations and the national standards.	Daily handover proforma has been revised to include a review of daily handover documentation of each child's daily care record which will promote more efficient filing practice. Completed 01.04.2022 Child care record system is under review by working group to ensure all information as specified in the regulations and national standards is easily accessible – this includes a cross referenced, 'blended' care record system for each child which comprises both electronic and hard copy information. Working group to present revised 'blended' electronic and hard copy childcare record system, with cross reference guidance, and amended care record audit proformas by 27th May 2022.	Monthly care record audit using revised 'blended' electronic and hard copy to be completed by deputy manager. Reviewed by centre manager and discussed as standing item in monthly supervision meetings. Quality assurance and governance officer to include quarterly audit of Care Record in centre audit schedule. Placement progress reports proforma has been amended to highlight the need for a care plan review and highlight whether the CICR minutes have been received. This new proforma will ensure that all care plans and CICR minutes have been received in a timely manner and held on files in line with the specified regulations and the National Standards.

	The centre manager must ensure that goals named in placement plans are tangible and effective planning takes place to achieve these.	Training in person-centred planning including SMART goal planning to be facilitated with staff team to support tangible goal setting and effective planning to meet same. Scheduled for Team Training 6th May 2022. Quarterly placement plan reviews to be scheduled by 6th May 2022. These meetings will include centre manager, deputy manager, keyworker (social care leader) and co-keyworker (social care worker) for each resident young person. Reviews will inform monthly key work planning meetings for each young person. Monthly key work meetings for each resident be scheduled by 6th May 2022 with the key work schedule a standing item on the agenda. Key work planning schedule proforma will be completed by 3rd May 2022.	Person-centred planning training will be included in the core training for all staff and will require refresher training at least bi-annually. Quality assurance and governance officer to include quarterly audit of placement plans, and associated records in centre audit schedule.

	The centre manager in conjunction with key workers must ensure that the ICSP, AMP and behaviour support strategy document for both young people is kept up to date to reflect their current needs and behaviour and appropriate interventions by staff.	The formal review of the ICSP, AMP and behaviour support strategies will be a standing item on the agenda for monthly key work meetings to be scheduled by 6th May 2022. Review of ICSP, AMP and behaviour support strategies will be included as a key element of accident, key work, contact and complaints records and other relevant records to promote the timely recording of updates as required. Revised proformas will be completed by 27th May 2022.	Quality assurance and governance officer to include quarterly audit of ICSP, AMP and behaviour support strategies and associated records in centre audit schedule.
	The centre manager must increase the awareness of both young people and team members on external complaints systems available such as Tusla's '*Tell Us*' and the Ombudsman for Children's Office.	Tusla 'Tell Us' and Ombudsman for Children's Office external complaints systems will be revisited in staff training scheduled for 6th May 2022. Key work to support each young person's awareness of the Tusla 'Tell Us' and Ombudsman for Children's Office external complaints systems will be included on the key work schedule for May 2022.	This key work topic to be revisited at least bi-annually with each young person and included in each young person's key work plan. Monthly review of placement plans and key work plans. Quality assurance and governance officer to include quarterly audit of placement plans and key work plans in audit schedule.
5	The registered provider must	Quality assurance and governance officer	Quality assurance & governance audit plans

	ensure that the auditing framework schedule is adhered to, and findings overseen by a suitably experienced person.	appointed on the 01.11.21, complies with required qualification and experience required to undertake the role. The officer has begun the process of monthly quality audits to ensure compliance with all elements of the National Standards and other relevant legislation and guidance at the centre	and outcomes to be presented to director of services monthly.
	The registered provider and the centre manager must embed the practice of reviewing significant events and ensure the learning from these reviews is recorded and shared with the wider team.	The management team meeting proforma has been updated to include the recording of key practice developments to be relayed to the wider staff team at team meetings. The team meeting proforma has also been revised to detail the key learning points identified from within the staff team and also feedback from the Significant Event Review Group. These amendments will ensure that key decisions highlighted in the Management Meetings is recorded appropriately and shared with the wider staff team.	Monthly management meeting will include SEN review group feedback to the staff team.

	The centre manager must develop a delegation record with the deputy manager and ensure that key decisions made in their absence are recorded.	The delegation record has been revised to ensure that all key decisions made in the managers absence are recorded.	
	The registered provider must ensure that policy and procedure training is satisfactorily completed by all staff.	Policy and procedure training in has been scheduled in the training calendar for 2022. All participants in this mandatory training are required to complete written records to evidence their understanding of same. All training will be revisited in supervision to support each staff members knowledge, skills and values development as they apply policy and procedures to their practice.	Policy and procedure refresher training will be offered at least twice yearly across the organisation – it is mandatory that all staff attend at least one of these annually.
	The registered provider must ensure that a social media, IT, email and internet use policy is developed.	Social media and internet policy is currently under review, due date 24th June 2022.	All policies will be reviewed annually, or sooner should legislative or regulatory guidance require same.
	The registered provider must	Corporate risk register has been updated	Review of the corporate risk register will be

	ensure that the corporate risk register is kept up to date. The centre manager must ensure that all staff understand how to identify, assess and manage risks and these are appropriately recorded and not generic assessments.	and review has been added as a standing item to the management meeting to be discussed no less than quarterly. The centre manager, in liaison with the registered provider, will source and schedule relevant risk assessment training for all staff, ensuring that the content of focuses on the knowledge and skills required to identify, assess and manage potential risks by 27th May 2022.	evidenced in the quarterly minutes and in the frequency of the review of same. Risk assessment and management refresher training will be offered at least twice yearly across the organisation – it is mandatory that all staff attend at least one of these annually.
6	The registered provider must ensure that a sufficient number of suitably qualified staff members are employed to meet the needs of the young people. The centre manager must ensure that garda vetting	The organisations staffing complement now complies with Service Type 2 – Medium Term Dual Occupancy Mainstream – staffing requirement, National Private Placement Team (NPPT) 2021. The organisation will continue to make efforts to ensure that unqualified staff obtain a social care qualification. Outstanding garda vetting renewals are currently being processed. The centre	Workforce planning included on monthly management meeting proforma as a standing item. An audit of personnel files completed quarterly by Quality assurance officer as per

	renewals are completed immediately.	manager and deputy manager will review personnel file audit summary monthly to ensure effective planning for renewals is actioned. Audit of personnel files completed in March 2022.	the personnel file audit summary proforma – includes garda vetting renewal compliance audit.
	The centre manager must ensure that outstanding mandatory training is planned for and completed in a timely manner.	An annual training calendar has been compiled to ensure that outstanding mandatory training is planned for and scheduled in a timely manner. Annual training to be scheduled for remainder of 2022 and beginning of 2023 by 24th June 2022.	An Audit of personnel files completed quarterly by quality assurance officer as per includes mandatory training audit.
	The registered provider must ensure that supervision takes place in line with the centre's policy and records are kept on file.	The monthly rota will outline the supervision schedule for each month. The proforma for supervision records has been revised and will be implemented for all supervision meetings taking place from 1st May 2022. Supervision training will be scheduled for all staff - supervisors and for all supervisees by 24th June 2022. Re-	Review of quality assurance audits will be added to the managers supervision session as a standing item. Management meetings include a review of supervision meetings at the centre and provides a forum to review compliance with policy and the National Standards.

		structuring of supervision provision will be completed upon the satisfactory completion of supervision training for all. By 22nd July 2022.The quality assurance and governance officer has begun completion of relevant audits to ensure compliance and includes monthly overview of the supervision records held on each employee's file.	