An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 071

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Smyly Trust**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**20th, 21st & 22nd September 2022**
Registration Status:	**Registered with attached conditions from 30th April 2020 to 30th April 2023**
Inspection Team:	**Lisa Tobin** **Eileen Woods**
Date Report Issued:	**31st January 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 in 2002. At the time of this inspection the centre was in its seventh registration and was in year three of the cycle. The centre was registered without attached conditions from 30th April 2020 to the 30th April 2023.

The centre was registered to provide a multi-occupancy service, for medium to long term care for up to four young people of both genders from age twelve to seventeen years on admission. Their model of care was described as providing residential childcare for young people using a therapeutic community approach to meet their emotional and developmental needs within a caring and stable structure. The model was based on five principles of attachment, containment, communication, citizenship and reflection. The goals were to be attained through individual work, group work, and family involvement. 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
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.1, 3.3
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.

The inspectors noted that there were issues with staffing when interviewing the centre manager and expanded the inspection process to include the review of standard 6.1.

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 22nd November 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 1st December 2022. The findings of this inspection deemed that the centre was not operating in compliance with the requirements of the National Standards for Children's Residential Centres, Theme 6: Responsive Workforce, Standard 6.1 due staffing issues related to stability and availability of staff team and managers.

The findings of this report and assessment of the submitted CAPA deem the centre to be not 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 : 071 with attached conditions from the 30th April 2020 to the 30th April 2023 pursuant to Part VIII, 1991 Child Care Act. The condition being:

- The centre must fully implement the actions identified in the corrective and preventative action plan so the availability of members of the staff in the centre are adequate, having regard to the number of children residing in the centre and the nature of their needs. The condition will be reviewed on or before 3rd April 2023.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

Inspectors reviewed the young people's files and centre documents to clarify where the young people's voices were captured in the centre. Young people attended their child in care review (CICR), strategy meetings and participated in community meetings with their peers and staff. Inspectors found while looking at a sample of records that there had been times where community meetings weren't happening and had not been reviewed or tracked. The centre manager must ensure that community meetings occur as scheduled and that a periodic review of the minutes of those meetings occurs for tracking of patterns and issues. This was a space where young people voiced any issues within the centre they wanted changed, where staff brought up any house related issues, general check-ins occurred, and young people were informed of any new referral. They discussed any upcoming activity for the centre. Community meetings were due to occur daily, and inspectors noticed this wasn't the case and that when they were held, some of the minutes were poorly recorded.

Inspectors saw while onsite the relationship staff had built with the young people. Inspectors witnessed staff interaction with one young person where there was an openness in discussing ongoing issues and the staff all spoke positively to encourage and guide the young person in making the right decision for themselves. There was an acknowledgement to the young person of how far they had progressed since they arrived to the centre and a celebration of their time in care was marked by the team with balloons, flowers and lights as seen by inspectors while at the centre.

There was a complaints policy in place which was reviewed earlier this year. It outlined the processes in place for addressing complaints: Local resolution, referral to the centre manager, internal review by the director of service and an external investigation by the social work department. The complaints were forwarded to the social workers via significant event notifications as part of this process. There were

no complaints recorded in the complaints register since the last inspection in October 2021.

Inspectors were informed that any grievances that came up could be addressed at the community meetings. Any grievances in general were documented in the young people's files on a log. Inspectors did not see evidence of grievances discussed at the community meetings in the sample reviewed or any other relevant paperwork completed for the young people around the local resolution process.

There was a grievance log in place which was overseen by the centre manager. The grievance log documented that these were resolved locally by staff however inspectors did not see the documentation showing this process. Some required involvement from the centre manager. There was one grievance outstanding that was currently on pause due to other ongoing issues for that young person. Inspectors saw that the young people had been offered the complaints procedure but had refused. There were manager comments attached to the end of each grievance however, the only outcome identified was that the young person refused complaints form rather than if they were satisfied with the feedback they were given. Thresholding of grievances was discussed during interview with the director of services who stated that this would be decided by the team. Inspectors queried grievances that were against staff or about young people feeling they were treated differently to their peers. The director stated that there was a review of the grievance trends underway, and they may need to change the paperwork. This required review on all levels as there was a lack of clarity on thresholding and on how the different types of complaints from young people were managed by staff and senior management. The centre manager must correctly identify grievances that the young people had made and escalate these to a formal complaint where necessary.

As there were no complaints on file and only grievances, inspectors could not see how the grievances were reviewed. Staff informed inspectors that grievances were mentioned in team meetings however staff stated they could be developed and discussed further by the team. The minutes from the team meeting regarding complaints or grievances were minimal and required further information about the discussions had in addressing the issues, discussing the outcome and ensuring feedback occurred so that all staff were aware of the process. Staff were aware of the local resolution documents available however could not recall when they were last utilised. There was insufficient oversight both internally by centre management and externally by the director of service of the complaints processes in monitoring how

the complaints process was tracked and how learning outcomes were identified for future service development.

Two of the young people that completed questionnaires were able to identify staff they could speak to if they had a complaint. The young people were informed of the complaints process by staff on their admission and again when they raised any issues. Young people were informed of external support services available to them such as Empowering People in care (EPIC), Tusla's Tell Us complaints process and the Ombudsman for children. The young people had the opportunity to attend sessions in a sister house where a social skills programme occurred. EPIC representatives had visited this in the past and met the young people that attended.

Family members, guardians and social workers were informed of the complaints process at admission. Social workers stated they were not aware of any outstanding complaints or issues and said that any issues were dealt with by the team and they were informed through the key working report or over the phone.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
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 1.6**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that community meetings occur as scheduled and that a periodic review of the minutes of those meetings occurs for tracking of patterns and issues.
- The director of service and centre manager must review the complaints processes in place to ensure there is appropriate thresholding in place for any issues or concerns that are raised by the young people.
- The director of service and centre manager must ensure the relevant documentation is in place to show the processes that were undertaken as part

of the complaint which includes feedback from the young people and the outcome of the issues or concern.

- The director of service and centre manager must ensure that when the community meetings are discussed at team meetings, the minutes of both the community meetings and of team meetings must outline the details of those discussions and any relevant actions required.

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.

There were child protection policies and procedures in place which had been reviewed in March 2021. There was a child safeguarding statement (CSS) in place with identified risks and there was a compliance letter from Child Safeguarding Statement Compliance Unit. The designated liaison person (DLP) or deputy DLP were not identified on the CSS. Mandatory training for the staff included Children First both e-learning and in person training, first aid and training in a recognised behaviour management model. From the training schedule provided to the inspectors, there were gaps identified in all areas of mandatory training. There were three staff names missing from the training schedule that were named on the staff information form, therefore inspectors were not aware of what training they had undertaken. Inspectors were due to receive an updated version of the training completed by all staff, however this was not sent on to review. All staff must complete mandatory training as per centre policy.

Inspectors interviewed staff and they were aware of their role as mandated persons and knew the processes involved in reporting a concern or disclosure. Staff were registered on the Tusla portal and knew the centre manager was the DLP. There was a child protection welfare report form (CPWRF) register in place which detailed the concern logged; however, inspectors could not verify the status of the concerns as the majority of the outcomes were stated as "MDT informed" (multidisciplinary team informed). There were a number of CPWRF's that had not been printed from the portal as inspectors noted some were missing from the folder. Further review is required to ensure the status and outcome was clear of whether a child protect report was opened, closed or under investigation.

Inspectors saw that there were risk assessments or safety plans put in place regarding some of the CPWRF's that had been reported. These were reviewed at team meetings and staff were aware of certain actions that had been put in place to ensure the safeguarding of the young people. Inspectors saw evidence of key working and individual work where staff discussed the ongoing safety concerns.

There was a bullying policy in place and bullying was not identified as an issue in the centre at present. Staff had identified areas of concern regarding safety for the young people and completed risk assessments, safety plans, updated individual absent management plans (IAMP's) and individual crisis support plans (ICSPs) regularly. Inspectors noted that the paperwork used was not in line with the most recent behaviour management training. Centre manager must ensure staff utilise the most up to date paperwork relevant to the recognised model of behaviour management.

Inspectors saw that while there were detailed safety plans and procedures in place for two young people, one other young person had serious safety concerns identified in their documents. Inspectors found that this young person had inconsistent support and was now on their fifth keyworker in nine months. This resulted in long gaps in the work undertaken with the young person over the summer months. Inspectors noted the young person's files hadn't been updated over this period and could only see evidence of four key working sessions taking place between July and September. There were areas of work that had been identified to be completed with this young person from the outset of their placement in December 2021, included sex education, online safety and other related areas. Inspectors did not see these recorded until September 2022 after the young person had an incident and verbalised wanting to speak with their key worker about it. While speaking with the young person's social worker, inspectors were informed that the social worker felt the team were responding well to any issues the young person had and that this was a complex case with a lot of unknown history. The social worker had also commented on the number of key workers the young person had and how this inconsistency would have affected the ongoing relationship with the young person with so many changes. The social worker stated they were happy with the appointment of the new keyworker and felt this would be a positive relationship for the young person.

Inspectors noted that during interview staff were able to identify the vulnerabilities of each young person. Staff named the different interventions they had in place to support and address those issues with the young people. This was managed through their own training or through the use of external services such as counselling or psychotherapy that was put in place for the young people.

Inspectors saw the level of involvement with a multidisciplinary team for another young person and how the supports in place were benefiting the young person. Strategy meetings were arranged monthly for the young person to discuss and address any issues that had occurred. These were more regular if needed. Two young people identified that they felt safe in the centre in their questionnaires and that they would speak to the staff if they had a concern.

Social workers, guardians and family members were updated by the team regularly and plans had been devised about when they should be contacted by the team. Social workers stated they were updated by email, phone and by reports sent to them.

There was a policy and procedure on protected disclosures in place which staff were not clear of when interviewed as they were linking it to both a complaint and a threshold for a protected disclosure. There were concerns raised by staff about the procedure aspect of the policy and how the issues were dealt with regarding communication and feedback of the outcome of any such disclosure or complaint.

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

There was a policy on significant events which was reviewed in 2022. Inspectors reviewed the significant event register and the significant event review meeting (SERG) minutes. Incidents were logged appropriately in the register and were discussed at the team meetings by the staff and at senior management meetings. Inspectors noted that both incidents causing concern and positive incidents were reported on to the relevant people.

Family members and social workers were informed of significant events promptly by phone and email. A copy of the incident report was sent to the social worker in appropriate timeframes. Social workers stated that they linked with the centre around any incidents and assessed risk and safeguarding to the young people and arranged a strategy meeting if required. This communication guided any updates to the young people's safety plans, risk assessments, IAMP's or ICSP's when relevant.

The SERG meetings took place monthly and were attended by the Director, centre managers, deputy managers and staff in rotation. The format for the meetings changed in February 2022 and had a clear agenda. Incidents were discussed and shared learning was documented. When inspectors asked staff if the feedback from the SERG was given to the team, the inspectors received mixed responses in that

feedback was given but not necessarily all the time or discussed at length in a way that influenced practice.

The centre manager was responsible for overseeing the significant event notifications and added comments to the end of the reports as part of the process. The centre manager gave guidance as to who needed to be informed of the incidents and if any further follow up was required. Inspectors noted that there were a number of incident reports that had not been signed by the relevant staff members. Inspectors were informed that individual work was completed with the young people following an incident and when social workers were asked if they received the follow up work, they stated they had. Inspectors saw that a number of individual works and key working sessions had been completed with 2 of the young people and they were linked with incidents that had occurred however these written reports consisted of only a few lines and didn't give a clear understanding of the work completed with the young people. Inspectors did not see any debriefs that had occurred with staff following an incident and staff informed inspectors this was not in their general practice however would like it to be part of their practice. Inspectors were informed by staff that their supervision with management was sporadic.

The centre had an external audit completed on theme 3 at the start of September 2022, which gave the centre actions to complete which was intended to improve the care provided to the young people in the centre. Inspectors noted that some aspects of the deficits had been picked up by the audit however had not been acted on prior to the inspection.

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 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that the CPWRF register outlines the status and outcome of the concern whether it is opened, closed or under investigation.

- The director of services and centre manager must ensure that there is consistency around the safeguarding work completed with all young people and with dedicated staff appointed to oversee the work.
- The Board of management and the director of services must review the policy and procedures for protected disclosures and ensure staff are aware of these. They must ensure that if/when issues are raised by the team that appropriate feedback is given to the staff member involved, that all parties are satisfied with the outcome and that supports are put in place if required.
- The director of services and centre manager must ensure that feedback is given following SERG review to enhance the shared learning among the team.
- The centre manager must ensure all significant events are signed by staff and that key working or individual work linked to incidents are recorded appropriately for learning.
- The director of service and centre manager must ensure that staff receive appropriate supports following incidents in the form of debriefs or through the supervision process. Supervision must be in line with centre policy.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

Both the centre manager and the director of services stated that there was ongoing recruitment under way and that despite using numerous advertisements for posts in the centre, the people applying were not appropriately experienced for the role or they did not have the appropriate qualification. There were two staff out on long term sick leave and the deputy manager had given notice of resignation recently.

At the time of inspection, there was a centre manager, deputy manager, three social care leaders, six social care posts with one a job share, and seven relief staff named. Two of the staff team had not worked the roster since February and March which left a reliance on the relief staff. Another staff member left in June which again put further pressure on the team. This resulted in the centre manager and deputy manager having to assist on the floor when needed with the young people. On reviewing rosters from January 2022, inspectors saw that there were gaps in day shifts not being covered each month ranging from 4 – 11 shifts without a day shift

staff. There was also evidence of agency staff being utilised for live nights in March and April. Since the inspection took place, inspectors were informed that the centre manager had also handed in their resignation leaving the overall management structure and governance vacant within the centre. There was not appropriate availability of staffing in the centre to maintain the roster for the required amount of staffing to address the needs of the young people. As noted earlier, one young person was without an allocated key worker which impacted on the identified work being completed.

The staff were appropriately qualified and had the experience and competencies to meet the needs of the young people however there were deficits in training identified. Based on the training log given to inspectors, one staff member required Children first training, four required fire safety, five required first aid and five required training in a recognised behaviour management model. New staff were paired with experienced staff on the roster as much as possible to ensure consistency with the young people. Staff informed inspectors during interview that there was an ongoing problem with staffing availability and that this led to staff at times not getting the leave they requested or being asked to return to work early from their leave to assist with cover.

Inspectors also noted there were concerning gaps in the supervision support to the staff where they discussed the young people and evaluated plans for the young people. Supervision with the staff team was not completed in line with centre policy, was not in line with service delivery and where records were on file, they were largely illegible.

While reviewing documentation inspectors found that oversight of the roster was not being carried out by the manager in a timely manner. Inspectors were informed this was an oversight by management at the time and clarified this issue would be addressed.

Workforce planning was discussed at senior management meetings and the ongoing issues with recruitment was fed back to the board of management. Other ways of attracting staff to the roles in the centre was discussed and inspectors were informed of staff that had been offered roles, but had taken up posts with other services or agencies. The staffing information form named 7 relief staff available for shifts and inspectors saw these staff used regularly on the roster. Inspectors noted when reviewing the training log that it only had information for 4 of these relief staff. The

centre manager must ensure that training information was available for all staff employed in the centre.

Staff informed inspectors of their dedication to the therapeutic care approach and to the young people in the centre. The staff informed inspectors that there were supports available to the team through a process group which occurred monthly. There was an Employee Assistance Programme available to the staff team should they wish to utilise it. Despite these arrangements in place, staff spoke of the impact the level of uncertainty in the service, coupled with the lack of support and a perceived lack of feedback from issues raised by staff was having on them.

There were on-call procedures in place which was overseen by centre managers and deputy managers. The staff were aware of who was on-call as those on-call were named on the handover based off a rota. There was a mixed response from staff when queried about the use of on-call and the nature of contacting them. Staff were unclear about when they should contact on-call due to previous experiences and this required review with the team.

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	**None identified**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The director of services and the centre manager must ensure that the centre has the staffing availability in place to meet the needs of the young people.
- The centre manager must ensure that all staff have undertaken mandatory training required as per centre policy.
- The director of service and centre manager must review the procedures around on-call with the team.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure that community meetings occur as scheduled and that a periodic review of the minutes of those meetings occurs for tracking of patterns and issues	The centre manager will ensure meetings are held in line with the principles of a Therapeutic Community. The centre manager will review the minutes of the community meetings and record themes in the staff meeting. This is with immediate effect.	The Director is looking at training in the Concept of Community Meeting as guided by the Principles of a Therapeutic Community. The Manager will now track the patterns for future learning.
	The director of service and centre manager must review the complaints processes in place to ensure there is appropriate thresholding in place for any issues or concerns that are raised by the young people.	The Director and Centre Manager will treat all concerns as complaints and will be dealt with in line with the complaints policy. This will come into operation January 2023. The Director will ensure there is appropriate thresholding in place.	All concerns will be dealt with under the Complaints Policy & Procedures.
	The director of services and centre manager must ensure the relevant documentation is in place to show the processes that were undertaken as part of the complaint which includes	The centre manager will record the process and include feedback to the young person. This is with immediate effect.	The Reporting Templates will include feedback to the Director. The Complaint log will be amended to show feedback to the young people. Our Complaints log will register the outcome of the feedback to the

	feedback from the young people and the outcome of the issues or concern. The director of service and centre manager must ensure that when the community meetings are discussed at team meetings, the minutes must outline the details of those discussions and any relevant actions required.	 The community meetings are discussed at the team meeting. The discussion will be recorded in the minutes. This will start immediately.	young people. The Director will review the community Meetings minutes on a regular basis.
3	The centre manager must ensure that the CPWRF register outlines the status and outcome of the concern whether it is opened, closed or under investigation. The director of services and centre manager must ensure that there is consistency around the safeguarding work completed with all young people and with dedicated staff appointed to oversee the work. The Board of management and the director of services must review the policy and procedures for protected	The centre Manger will now register the outcome of the concern on the register. This is with immediate effect. The centre manager will ensure consistency and appoint the keyworker to complete necessary work around safeguarding. The Policy was reviewed in 2022. It will be reviewed again in 2024. The Policy will now form part of our Training Programme	The organisation will review the CPWRF register at its management meetings, and it is then reported to the Board of Smyly Trust Services. The organisation will continue to provide ongoing training and supervision in regard to safeguarding. The organisation will include training in Protective Disclosure as part of its ongoing programme in the first quarter of 2023.

	disclosures and ensure staff are aware of these. They must ensure that if/when issues are raised by the team that appropriate feedback is given to the staff member involved, that all parties are satisfied with the outcome and that supports are put in place if required.	delivered by our Social Care Leaders with responsibility for Training. The director will ensure that issues that are raised are fed back appropriately to those involved and supports put in place as required.	This will be evidenced in their Personal files, Education & Training Group Minutes and Education & Training Meetings. The organisation promotes the concepts of Protective Disclosure.
	The director of services and centre manager must ensure that feedback is given following SERG review to enhance the shared learning among the team.	The centre manager will provide feedback to the team after the SEN review Group. The learning will be recorded in the team meetings.	The SENRG minutes will be circulate to all the teams.
	The centre manager must ensure all significant events are signed by staff and that key working or individual work linked to incidents are recorded for learning.	All SEN will be signed by staff and incidents and individual work will be recorded through keyworker notes detailing the learning. This will happen with immediate effect.	The Learning around individual work will be present at the SENRG and will inform learning for our teams. Young People are profiled and presented in line with interventions. Data is collected from SEN and analysis.
	The director of service and centre manager must ensure that staff receive appropriate supports following	The centre manager will ensure that Supervision is in line with policy with immediate effect.	The Process Group allows staff a safe space to discuss/debrief incidents. The Manager & Director are available to support staff

	incidents in the form of debriefs or through the supervision process. Supervision must be in line with centre policy.		after a serious incident. The Employee Assistance Programme is available to all employees.
6	The director of services and the centre manager must ensure that the centre has the staffing availability in place to meet the needs of the young people. The centre manager must ensure that all staff have undertaken mandatory training required as per centre policy. The director of service and centre manager must review the procedures around on-call with the team.	The Director continues to advertise and recruit staff. This is an ongoing process. Training for all staff will be completed on a scheduled basis commencing in January 2023 with Children's First. The Director has reviewed the on call with the managers of Smyly Trust Services. The Director will email the team after reviewing the On Call.	The organisation continues to recruit to ensure the centre has the availability in place to meet the needs of young people. The organisation is committed to training all our staff. We now have trained 2 members of the team to be Train the Trainers and will start to deliver core training. The Director has approved 2 social care workers to be trained in Therapeutic Crisis intervention in February 2023. The Director continues to address the issue At Service Level Arrangements. To date this has not been resolved. The organisation will monitor, review, assess and respond appropriately.