



An Ghníomhaireacht um  
Leanaí agus an Teaghlach  
Child and Family Agency

## Alternative Care - Inspection and Monitoring Service

### Children's Residential Centre

**Centre ID number: 083**

**Year: 2025**

## Inspection Report

<b>Year:</b>	<b>2025</b>
<b>Name of Organisation:</b>	<b>Rainbow Community Services Ltd</b>
<b>Registered Capacity:</b>	<b>Five Young People</b>
<b>Type of Inspection:</b>	<b>Announced</b>
<b>Date of inspection:</b>	<b>24<sup>th</sup> &amp; 25<sup>th</sup> of February 2025</b>
<b>Registration Status:</b>	<b>Registered with conditions attached from the 19<sup>th</sup> February 2023 to the 19<sup>th</sup> of February 2026</b>
<b>Inspection Team:</b>	<b>Eileen Woods Catherine Hanly</b>
<b>Date Report Issued:</b>	<b>12<sup>th</sup> of December 2025</b>

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# 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 19<sup>th</sup> of February 2008. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle.

The centre was registered to provide accommodation to five young people of all genders from age twelve to eighteen on admission. Their model of care was described as relationship based and trauma informed. There were four young people living in the centre at the time of the inspection, one of whom was resident elsewhere for a defined period of time.

## 1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.4
7: Use of Resources	7.1

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 4<sup>th</sup> of April 2025. 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 23<sup>rd</sup> of April 2025 and evidence was provided of actions taken by the management, the CAPA itself was not deemed to adequately address the preventative measures. A second CAPA and additional evidence was provided on the 9<sup>th</sup> of May 2025. Due to the matters arising the centre had been internally escalated to the ACIMS National Registration Enforcement Panel, NREP on the 4<sup>th</sup> of April 2025.

The findings of this report and assessment of the submitted CAPA and subsequent review to the NREP 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:083 with attached conditions from the 19<sup>th</sup> of February 2023 to the 19<sup>th</sup> of February 2026 pursuant to Part VIII, 61(6)(a)(i), 1991 Child Care Act. The following are the conditions attached to the centre's registration under section 61(6)(a)(i) of the Act:

1. The improvement plan provided by the registered proprietor is implemented in full by December 2025 as stated in the plan, resulting in improved governance and a fully compliant centre.
2. No more than three children are to be admitted to this centre at any one time, until such time as the Agency is satisfied as to the sustained implementation the centre's action plan as provided to the Agency.

### 3. Inspection Findings

**Regulation 5: Care Practices and Operational Policies**

**Regulation 6: Person in Charge**

**Theme 5: Leadership, Governance and Management**

**Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.**

This centre had been inspected and reviewed by the inspection service three times in this current inspection cycle, commencing February 2023, prior to this inspection. This included an inspection visit, a review of conditions attached and an inspection by the ACIMS risk response team. Thematically there were ongoing issues identified in child protection and safeguarding awareness, risk assessment and management of those risks, including in the areas of group impact and in admissions. At the start of this inspection a number of allegations had been made and an investigation process started. The inspectors do not have a role in investigating allegations but take account of information arising relating to good risk management, decision making and deployment of staff.

In relation to the previous inspections on each occasion that requirements were placed on the centre by inspectors they responded with a plan of action through a corrective and preventative action plan. There was no specific tracker for the corrective and preventative action plans/CAPAs completed for inspection and this is recommended as a mechanism for ensuring progress is made. There was evidence of some tracking of inspection report actions within audits and gaps or delays highlighted for attention. What inspectors found was that once matters were identified by inspection and audit these were then acted upon. They were added to team meetings and discussed in supervision. The goal now needs to be more effective risk awareness, team management and self-identification of areas for development that can be turned into a proactive quality assurance model for the centre.

Inspectors found that the staff were aware of the key areas of development and practice improvement that had been identified by previous inspection and by organisational audit. The centre had also been internally audited in August 2024 and in December 2024 with actions identified for the management team to address. The audits did not identify the persons completing them, when they were completed and

set timelines for expected returns as well as the committed to completion dates. The audits had been effective in identifying some ongoing areas that required improvement as well as areas that were being effectively implemented for young people

Additional mechanisms for review of the safety and quality of care delivered to young people were contained within the bi-weekly centre management reports to the director. The director noted comments and gave some direction for practice in response to these. There were monthly managers meetings held, and these were minuted with actions generated from them. Following review of the records inspectors identified two key areas of development requiring action, these were a structure for policy development and the role and function of significant review, referred to as SERG, in the assessment of direct care delivery. These were largely absent from the various forums in place, such as the team and managers meetings and training records. The centre management team and the director must look at wider policy development, put in place a structured rolling system of review and bring wider policies for team learning and attention, not just policies identified by inspection and audit.

The centre had two formats in place for SERG. These were available on file, one involved tracking per significant event notification/SEN and the other looking at grouped SEN's. Staff were not aware of SERG outcomes and the SERG process presented as a missed opportunity for sharing analysis, for example trends, patterns in staffing or outcomes of interventions. Inspectors recommend that the SERG process be expanded to highlight recurring trends and that the SERG reports and outcomes be discussed and reviewed at team meetings.

The social workers and other professionals interviewed stated that they received significant event reports in a timely manner and that they had collaborated in multi-disciplinary strategy meetings in response to critical situations as they arose. Inspectors also received feedback that when external professionals raised a need to better identify and report group impact that these improved to allow for safeguarding for all residents during incidents. The centre had implemented an escalation policy and this was evidenced in practice as adding an important layer to their safeguarding work. The centre management and the director implemented increasing levels of involvement and response when placements were at risk.

Risk management had been enhanced through training for senior staff and individual risk trackers for young people had been introduced based on inspection feedback.

These demonstrated the mitigations put in place, they were reviewed regularly and shared with the director.

Overall, the inspectors found that staff did not know what trends if any had occurred in complaints, for example in the day to day aspects of local complaints. They could point to one or two larger complaints but not what wider learning or changes had taken place, or not, in response to complaints. The team meeting and the managers meetings had dedicated sections for complaints and these contained little information and must be better utilised to assess progress in this area. The young people themselves fed back to inspectors that when it came to complaints that they could talk to staff and “it was dealt with fairly” by “caring staff”, another was not satisfied with staff practice and follow up in the area of complaints and it was clear residual areas of tension remained between some young people. Inspectors could not find robust evidence to demonstrate that the shared living experience of all young people and the context of their previous trauma were considered.

The team meetings were scheduled weekly, with a monthly session in person with a team facilitator. The description of the purpose of the latter sessions ranged from classic team facilitation through to advice on interventions with young people. Inspectors recommend that this be clarified as to what comes back as applicable advice for direct work. The team meetings overall should begin to evidence policy more clearly and regularly and the staff should be aware of a structure and process for policy development. Complaints, child protection, incidents were sections on team meetings, however details were not recorded. Inspectors found that there was a lack of detail recorded in key areas and that the centre management must establish a standard of appropriate recording. In person team meetings were rarely held and inspectors recommend that these be increased in order to model good recording and discussion as well as to enhance team communication. It emerged during the inspection process that on occasion staff were not sharing issues that had arisen or come to their attention and the centre management must create an environment where open discussion and constructive challenge can take place.

This was a large team, supporting young people in crisis, at the end of 2024 this involved being in different locations involving travel in order to sustain a placement. Inspectors found that external professionals noted a number of communication issues and that with a large team it was hard to speak with known staff once outside the centre manager and deputy.

Inspectors found that taking account of the information related to the busyness of the centre and other information that additional training in the code of behaviour that foregrounds accountability to consistently place the needs of the young people to the forefront of the work, whilst ensuring good safeguarding, is required. The organisational management must satisfy themselves as to suitable safeguarding and practice accountability within the centre. As part of this they must examine their lone working policy and risk assessment approach which allowed for a repeated pattern of remote lone working overnight with a young person during a time of high risk.

The centre management team had clearly designated tasks for other staff members with the centre manager holding overall responsibility. Inspectors found that some of the delegated tasks should be kept under review to ensure the best or most useful output from them in terms of use of resources. The director had completed an annual report, this runs May to May and a copy of the 2023-2024 report provided was well structured and looked at the full organisation, within that there were plans for development of the organisation and a general satisfaction with the level of compliance.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 5 Regulation 6</b>
<b>Regulation not met</b>	<b>None Identified</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices met the required standard in some respects only</b>	<b>Standard 5.4</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- The director of service and centre manager must ensure that the internal governance and oversight mechanisms are robust and accountable for the safety and development of this centre as part of a proactive quality assurance model for this centre.
- The centre management must review the significant event review process to ensure that effective analysis and learning is shared with all staff and thereafter integrated as needed into the direct care of the young people and into staff development.

- The director of care and centre management must evidence review of complaints, incidents and child protection matters for learning and safety purposes. This information must thereafter be shared with staff in a manner focused on service improvement.
- The centre management and staff must ensure that a suitable and consistent standard of recording on team meetings minutes in order to evidence review of all complaints, child protection and incidents.
- The director of service and centre management must ensure that there is a programme of team development that includes training in the centres model of care and values, in the code of behaviour and professional practice.

### Regulation 6: Person in Charge

### Regulation 7: Staffing

### Theme 6: Responsive Workforce

### Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

There was a record of mandatory training in place, the manager identified that they reviewed this quarterly, and staff stated that they were made aware when a renewal was required. The tracker provided to inspectors identified dates of mandatory training having been completed for staff or booked for renewal on upcoming dates. The centre manager confirmed for inspectors that they have set a two yearly renewal framework for the centres child protection and safeguarding training. According to the tracker staff had completed mandated persons training and the senior staff had completed designated liaison person, DLP, training. Inspectors found that upon review of a sample of child protection and welfare notifications sent from the centre that the centre manager was entering themselves as the sole reporter in both sections. Inspectors advised that they should review their training to ensure that if it is a true solo report then they can enter their own details and where it is joint, where information comes through staff, that this be a joint report. The director and centre manager had identified training in trauma informed care as an area for team training and inspectors found that this would be a positive addition to the training portfolio for staff. The centre manager also outlined a plan to source up to date training on digital safety and online awareness for all staff.

There was evidence of a history of funding additional training for staff upon request. Staff appraisals had been conducted in January 2025 and new areas of complementary training had been identified and approved for staff. The team had also received input from external clinical professionals, for example, CAMHS. Inspectors found that it was difficult to see if additional training completed by staff was brought back to the team in the form of a summary or feedback to the whole team. Inspectors found that it would be beneficial to track additional training that had been completed also.

There was a policy and procedure in place for inductions. There was one recent example related to an inductee and inspectors found that this record was incomplete. The person had started three months prior in the centre with their mandatory 'Introduction to Children First' eLearn training not completed until more than two months after joining the roster. This represents a failing in process and in safeguarding and systems must be put in place to ensure this does not recur.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 6 Regulation 7</b>
<b>Regulation not met</b>	<b>None identified</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices met the required standard in some respects only</b>	<b>Standard 6.4</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- The centre management must ensure that the full induction policy and procedures are followed and completed to a good standard. All mandatory training must be prioritised within a safe and timely timeframe with child protection and safeguarding to the forefront.

## Regulation 7: Staffing

### Theme 7: Use of Resources

#### Standard 7.1 Residential centres plan and manage the use of available resources to deliver child-centred, safe and effective care and support.

The inspectors found that upon arrival at the centre there were upgrading works taking place. This was part of an ongoing property improvement process that is required due to the condition of the property and needs of the young people. Some additional recent improvements were noted on flooring, furniture and painting. The centre had three cars to bring the young people to schools, employment, family and other types of access. Some of these journeys were at a distance and there were no reports of any lateness or lack of drivers to get the young people to where they needed to or wanted to go. Therefore, a young person was able to maintain a school, at a significant distance from the centre and sporting as well as social outlets that they had built up over their life.

The therapeutic needs of the young people were on occasion funded directly by the centre in order to avoid delays and the team supported sourcing or attendance at regular medical or mental health appointments with the young people. Outings, holidays with family, concerts and other entertainments were paid for. The centre upgraded their internal alarm systems in support of safeguarding within the centre. There were recorded issues with these which were noted on file. Repairs and servicing were completed within a short timeframe according to those records at the centre. Inspectors found that there were some recordings that suggested conflict between staff on occasion in monitoring these alarms but could not track where action had been taken to address this. It must be reviewed with the team that the monitoring of young people's safety within the centre is a key daily staff responsibility. Overall inspectors could not track where staff effectively challenged each other or brought issues to management to allow for them to be fully discussed and resolved.

The centre management team of centre manager and deputy manager oversaw the budgets and financial requests for the centre. They updated staff on the systems and timeframes in place for requests outside the scope of the weekly budget during team meetings. Inspectors found that overall there were few recorded complaints or concerns from the young people about the property and those raised were ultimately acted upon, including one raised during feedback to inspectors. Some external

professionals did note that the centre would have benefited from ongoing upgrading as well as improved security. Inspectors relayed the feedback to the management team and also noted that some of the key areas identified had already become part of a process of improvements, bathroom upgrades, new front door and back door locks and renewed internal door and window alarms. An additional recreational cabin had been built to the side of the property in this inspection cycle also.

At the time of the announcing of this inspection there were thirteen staff, separate to the management team. Of these four were social care leaders, two of whom worked half time and nine social care workers two of whom worked part time. This combined to eleven wholetime equivalent. During this inspection two full time staff have now become unavailable, bringing the numbers to nine staff available to cover a roster designed to have three staff sleeping over and additional staff, planned at that time, to do some remote work in support of a young person. These factors have to be carefully considered in planning for any admissions or returns to the centre to ensure safety, consistency and service delivery as priorities. Historically a staff member had been facilitated with a forty-eight-hour roster structure, inspectors observed that this was adhered to and was managed internally. It had been previously named to the director that such arrangements where they existed had to be the exception. Another staff had been facilitated for a period of time with this roster option but it was ceased when issues impacting rest and performance were identified.

It is important that the organisational management work in line with safe and consistent work practices. A review of rosters identified that aside from this that staff did on occasion work extra shifts and had one week in rotation with three sleepovers, this was followed by a quieter week with successive days off. There were colour coded trackers for worked rosters and these evidenced that excessive additional shifts did not appear to be taking place. Agency staff and staff from a sister centre were utilised to support the roster. The director and centre manager must review the staffing arrangements in line with their deployment for the numbers of young people and their needs in order to ensure that there is planning and availability including enough staff to safeguard the young people where joint working is required. There was evidence of a high level of flexibility and support for staff as well as demands relating to working at a distance from the centre for long periods of time. Learning and reflection must take place related to admissions, staffing levels and what it is safe to do and not do as a team.

The director of services received twice weekly reports from the centre and held monthly managers meetings at which finance and funding was discussed and actions

identified. There was evidence that the registered proprietor was committed to investing in what was identified to them regarding the service and property needs as well as for individual young people.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 7</b>
<b>Regulation not met</b>	<b>None identified</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices met the required standard in some respects only</b>	<b>7.1</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

#### **Actions required**

- The director of service and centre management must provide details of how the staffing levels will be managed during this period of investigation to ensure that the needs of the young people are met, prioritising safeguarding, good risk management and decision making.

## 4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	<p>The director of service and centre management must ensure that the internal governance and oversight mechanisms are robust and accountable for the safety and development of this centre as part of a proactive quality assurance model.</p>	<p>The DOS and centre management have reviewed the current internal governance, and oversight mechanisms to promote robust and accountable oversight mechanisms focused on the safety and development of the centre as part of the proactive quality assurance process.</p> <p>The DOS, as part of the quality improvement plan for 2025 has already commissioned an external agency to participate in the organisations internal audit process as part of enhancing oversight with the first of these audits having been completed on 30<sup>th</sup> of April 2025.</p>	<p>The DOS and centre management have met and agreed an outline restructure of the management and job descriptions to address this key issue. A recruitment process has commenced to appoint a management support function to separate core PIC functions from other administrative management functions. A successful candidate has been identified and is scheduled to commence employment on the 23<sup>rd</sup> of June. This new role has the purpose of releasing management time to focus on staff supervision, internal audit, training and development, policy development and implementation. This seeks to improve overall oversight focusing on proactive quality assurance with a key element of staff development.</p> <p>Centre management has immediately revised onsite oversight alongside team</p>

			<p>leaders, focused on supervision and oversight of all day-to-day working including</p> <ul style="list-style-type: none"> <li>•Review of Safe practise and lone working policy (completed and implemented, see team meeting 26/03/2025)</li> <li>•Review of daily logs, individual work, communication records</li> <li>•Frequency of check in while lone working</li> <li>•Revised contact and communication procedures</li> <li>•Ad-hoc check in by management</li> <li>•Formal monthly oversight with key-workers on YP records</li> <li>•Review of link between placement planning to key-working and individual works</li> <li>•Refreshed training on key-working and key-work record keeping</li> <li>•Adherence to supervision policy timeframes</li> </ul> <p>The centre management will also canvass the staff team for their input on their understanding of any gaps in knowledge, capacity, capability that can be addressed</p>
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	<p>The centre management must review the significant event review process to ensure that effective analysis and learning is shared with all staff and thereafter integrated as needed into the</p>	<p>The centre management will undertake a review of the SERG process to include detail on complaints and CPW by 09 May 2025. This will be aimed to ensure that effective analysis and learning is shared</p>	<p>to support upskilling and development in their roles to provide for further development and quality assurance.</p> <p>The centre management will undertake development in audit practice by 30/06/2025 to understand more fully the process and more readily identify any gaps allowing for actions to be undertaken to address any safety, development and quality concerns.</p> <p>The DOS has commissioned external audit which took place week commencing 28/04/2025 . As part of the CAPA response and feedback from external and internal audit the DOS will formally meet with centre management on a quarterly basis to review CAPA and Audit responses to sign off on actions completed.</p> <p>The centre management will undertake a review of the SERG process to include complaints and CPW's by 09 May 2025. This will sit within the leaders meeting to ensure the entire leadership team are</p>
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	<p>direct care of the young people and into staff development.</p> <p>The director of care and centre management must evidence review of complaints, incidents and child protection matters for learning and safety purposes. This information must thereafter be shared with staff in a</p>	<p>across the staff team and integrated into the direct care of young people and into staff development. This function will transfer to sit within the leaders meetings to ensure leadership participation and to assist in feeding knowledge to the team. The learning and sharing of the SERG process will become a standard item on team meeting agendas with sub-headings to highlight SEN's, Complaints and CPW. Actions arising from this will be allocated to individual staff/management with associated timeframes and sign off. All of this to be recorded in team meeting minutes and reviewed as per normal review at the following meeting for actions.</p> <p>The centre management will undertake a review of the SERG process to include detail on complaints and CPW. This will be aimed to ensure that effective analysis and learning is shared across the staff team and integrated into the direct care of</p>	<p>included.</p> <p>The analysis and learning will be shared will be shared to the team as a whole in the subsequent team meeting with actions arising allocated with associated timeframes and sign off.</p> <p>The centre management will undertake a review of the SERG process to include complaints and CPW's by 09 May 2025. This will sit within the leaders meeting to ensure the entire leadership team are included.</p>
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	<p>manner focused on service improvement.</p> <p>The centre management and staff must ensure that a suitable and consistent standard of recording on team meetings minutes in order to evidence review of all complaints, child protection and incidents.</p>	<p>young people and into staff development. This function will transfer to sit within the Leaders meetings to ensure leadership participation and to assist in feeding knowledge to the team. The learning and sharing of the SERG process will become a standard item on team meeting agendas with sub-headings to highlight SEN's, Complaints and CPW. Actions arising from this will be allocated to individual staff/management with associated timeframes and sign off. All of this to be recorded in team meeting minutes and reviewed as per normal review at the following meeting for actions.</p> <p>The centre management will undertake a review of the SERG process to include detail on complaints and CPW. This will be aimed to ensure that effective analysis and learning is shared across the staff team and integrated into the direct care of young people and into staff development. This function will transfer to sit within the Leaders meetings to ensure leadership</p>	<p>The analysis and learning will be shared will be shared to the team as a whole in the subsequent team meeting with actions arising allocated with associated timeframes and sign off.</p> <p>The centre management will undertake a review of the SERG process to include complaints and CPW's by 09 May 2025. This will sit within the leaders meeting to ensure the entire leadership team are included.</p> <p>The analysis and learning will be shared will be shared to the team as a whole in the subsequent team meeting with actions</p>
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	<p>The director of service and centre management must ensure that there is a programme of team development that includes training in the centres model of care and values, in the code of behaviour and professional practice.</p>	<p>participation and to assist in feeding knowledge to the team. The learning and sharing of the SERG process will become a standard item on team meeting agendas with sub-headings to highlight SEN's, Complaints and CPW. Actions arising from this will be allocated to individual staff/management with associated timeframes and sign off. All of this to be recorded in team meeting minutes and reviewed as per normal review at the following meeting for actions.</p> <p>The DOS and centre management will engage with training providers to ensure a full revision of the DLE training as the centres 'model of care', to be held no later than 30 Jun 2025. This is to be offered to all staff that have not received the training in over two years.</p> <p>There was an 'in person' team meeting 16/04/2025 which addressed outcomes of investigation and link to Model of Care, Codes of Behaviour and Professional</p>	<p>arising allocated with associated timeframes and sign off.</p> <p>The DOS and centre management will liaise with DLE training provider for a revision of DLE training across the team by 30 Jun 2025.</p> <p>The centre management have updated the Safe Practise and Lone Working Policy and presented this to the team 26/03/2025 and Drugs / Alcohol Policy, Health Policy 09/04/2025 .</p> <p>Further learning on service policy will take place on a monthly basis as part of a</p>
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		<p>Practise.</p> <p>Following on from this the centre manager will reintroduce regular policy review across themes 1 – 4 of the National Standards to be summarised and presented to the team on a monthly basis to promote understanding and discussion of the professional practise expectations within the service.</p>	<p>scheduled program of review of policies under Themes 1-4 of the National Standards.</p>
6	<p>The centre management must ensure that the full induction policy and procedures are followed and completed to a good standard. All mandatory training must be prioritised within a safe and timely timeframe with child protection and safeguarding to the forefront.</p>	<p>The organisation has a recently reviewed induction procedure which is being implemented. This aims to ensure that all aspects of the induction process are completed in a timely manner. As part of this new starter staff are required to provide evidence of completion of Children 1<sup>st</sup> and Mandated persons training prior to attending for their first onsite induction day.</p>	<p>The organisation has recently reviewed the induction procedure which is being implemented for all new recruits. This aims to ensure that all aspects of the induction process are completed in a timely manner. As part of this new starter staff are required to provide evidence of completion of Children 1<sup>st</sup> and Mandated persons on or before attending for their first onsite induction day or within the first day.</p>

7	<p>The director of service and centre management must provide details of how the staffing levels will be managed during this period of investigation to ensure that the needs of the young people are met, prioritising safeguarding, good risk management and decision making.</p>	<p>The DOS and centre management have worked with the staff team to ensure full staff cover provision during the period of investigation. This has included part-time staff participating in full time hours, some additional hours for full time staff who have offered to participate and the use of relief staff where necessary. Copies of the as worked rosters for the six weeks since commencement of the investigation are attached as evidence. The centre continues to provide staffing provision in excess of the contractual requirements and in response to young person need, and responding to the requirements of safeguarding, risk assessments and effective decision making regarding priority concerns for young people, staff and the centre.</p>	<p>The DOS and centre management have worked with the staff team to ensure full staff cover provision during the period of investigation. This has included</p> <ul style="list-style-type: none"> <li>• three part-time staff undertaking full time hours,</li> <li>• the use of relief staff where necessary.</li> </ul> <p>Copies of the as worked rosters for the six weeks since commencement of the investigation were provided. The centre has also engaged in recruitment and has secured additional staff to support the needs of the service.</p> <p>The centre continues to provide staffing provision in excess of contractual requirements and in response to young person need, and responding to the requirements of safeguarding, risk assessments and effective decision making regarding priority concerns for young people, staff and the centre.</p>
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