An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 097

Year: 2020

Inspection Report

Year:	2020
Name of Organisation:	Positive Care
Registered Capacity:	Four young people
Type of Inspection:	Announced
Date of Inspection:	21st,22nd, 23rd, 29th September 2020
Registration Status:	Registered from 22nd of December 2020 to the 22nd of December 2023
Inspection Team:	Linda Mc Guinness Anne McEvoy
Date Report Issued:	15th January, 2021

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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 Assurance 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 monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in December 2008. At the time of this inspection the centre was in its fourth registration and in year three of the cycle. The centre was registered without attached conditions from the 22nd of December 2017 to the 22nd of December 2020.

The centre's purpose and function was to accommodate up to four young people of both genders from age thirteen to seventeen years on admission. The centre endorses the SELF care framework and curriculum and it outlines the principles of therapeutic approaches and models which should underpin placements and overall therapeutic care. The model of care was relationship based and had four pillars: entry; stabilise and plan; support and relationship building; and exit. This model includes work on trauma and family relationships while setting meaningful life goals for the young person. There was an emphasis on understanding the young person's behaviour and helping them to learn healthy alternatives. There were three young people living in the centre at the time of inspection.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.2
6:Responsive workforce	6.1, 6.4

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.

This inspection was undertaken following the death of one young person in the centre on 10th September 2020 and issues related to that incident are included as an addendum to this report. This inspection report examines the care being provided to the young people in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA) and the Child Care (Standards in Children's Residential Centres) Regulations, 1996. The scope of this report refers to the three young people living in the centre at the time of inspection.

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 and centre manager on the 14th of October 2020 and to the relevant social work departments on the 14th of October 2020. 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 21st October 2020. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

Given the serious nature of the incident that occurred in this centre, the findings in this report along with those in the addendum report have been referred to the Tusla Children's Services Regulation, National Registration and Enforcement Panel. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 097 without attached conditions from the 22nd of December 2020 to 22nd of December 2023 pursuant to Part VIII, 1991 Child Care Act. This decision is subject to review by the National Registration and Enforcement Panel.

3. Inspection Findings

Regulation 17 Records

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.

Each young person in the centre had an up-to-date care plan. Review of files and interviews with supervising social workers evidenced that the team worked closely with them to implement all aspects of the care plan. There was also an up-to-date placement plan on file for each young person which had been prepared by their key worker and was communicated to the staff team and clinical team. The plan for each young person outlined the current issues, their individual needs and the supports required to implement the goals of the care plan. Where appropriate, families were included and there was evidence that young people were consulted and included in the planning processes. Each young person's plan set out specific goals for the keyworkers and team to work towards. These goals were reviewed regularly and young people moved through the pillars set out in the care framework as they progressed through placement. Inspectors found that each young person had been supported to access external specialist supports in a timely manner.

Compliance with Regulation	
Regulation met	Regulation 17
Regulation not met	None Identified

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

Regulation 16 – Notification of Significant Events

Theme 3: Safe Care and Support

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

The centre had a policy on supporting positive behaviour and the management of challenging behaviour. All staff had received training in the recognised model of behaviour management in use. Inspectors found that refresher training took place within the required timeframes. Interviews with staff and a review of records showed that staff were aware of the underlying causes of behaviours of concern. There were individual crisis management plans (ICMP) in place to assist and support staff and the young people to manage difficult behaviour. Each young person had an up to date ICMP and there was evidence of regular review of these documents.

Key working records evidenced that staff used their relationships with young people to support them to understand their behaviour and to challenge them when their behaviour was harmful to themselves or others. Social workers interviewed during the inspection process all stated that the team had the skills required to support their young person to manage their challenging behaviours and that the three young people in the centre had all made significant progress. The Guardian ad litem for one young person stated that the management and team were responsive when a different approach to care was required following direction from external clinicians.

The resident young people told inspectors that they were satisfied with the care being provided and also stated they liked the manager and staff team. They felt supported following the death of their peer and felt they had people that they could talk to.

During inspection interviews, staff were keenly aware of the impact of trauma, neglect and abuse and how these can impact on behaviours of young people. The clinical team had provided training in relation to the care framework. Notwithstanding this, inspectors found that there was a lack of practical guidance and direction from the clinical team to the staff team in relation to issues the young people were presenting with that could influence their behaviour. The policy in respect of planning for young people stated that each young person would have a therapeutic plan which would be written by the organisations' psychologist. A review of these documents found that they contained a description of the young people's

history, current presentation and staff observations and concerns. Most of them did not contain identified target areas as set out in the template or suggested interventions from the clinical team. In the case of one young person, the directions to staff through their therapeutic plan, on interventions and work to support them were not sufficient.

The therapeutic plans which did contain notes/comments from the psychologist were often written in explicitly clinical language and suggested further reading rather than practical advice and guidance for day to day work with young people. The management team acknowledged deficits in the therapeutic planning process and that therapeutic plans were incomplete. On 21st April 2020 the management meeting record showed that the process of updating therapeutic plans had commenced with information gathering for the psychologist. These therapeutic plans were still not complete at the time of this inspection despite being highlighted at numerous management meetings. This was most recently highlighted in the management meeting on September 01st 2020.

Inspectors found that the centre adhered to its own policy in that there was an emphasis on rewarding positive behaviour rather than a reliance on sanctions. Inspectors reviewed consequences and sanctions on file and noted that these had been explained to young people, were proportionate and related to their specific behaviour. The sanctions were reviewed and reduced if young people engaged in a learning or restorative process.

Behaviour management approaches were reviewed regularly at team meetings and through the organisation's significant event review group and auditing processes.

In respect of behaviour management, inspectors found that there was a process for the escalation of risk within the centre and the organisation. Any score above 15 on the IRMP risk matrix was immediately escalated to the organisation's regional manager and scores above 20 to the client services manager. There was evidence that the risks for young people were discussed at senior management meetings within the organisation. Following escalation, the centre manager and regional manager also met with social workers for young people to discuss strategies for managing risk.

There were individual risk assessments and risk management plans in place for each young person. These were updated regularly based on current issues for young people and higher level risks were escalated appropriately. Each young person's IRMP had been updated following the death of a young person in the centre to take

into account possible risks associated with the impact of this distressing event on them. All supervising social workers were included in this process. There was evidence that the regional manager and the client services manager had oversight of significant events that occurred in the centre.

Each young person had an up to date individual absence management plan which was required under the *Children Missing from Care: A Joint protocol between An Garda Síochána and the Health Services Executive, Children and Family Services, 2012'*. There was evidence that these were updated in line with the protocol and the plans outlined strategies to minimise the absences and associated risks.
There was evidence of good interdisciplinary working between the centre, Tusla and An Garda Síochána and meetings took place within the timeframes set out in the protocol when absences were considered high risk. There was also escalation to the appropriate layers of both social work and Garda management in line with the requirements of the protocol when required.

There was a policy in respect of the use of restrictive practices which inspectors found was fully understood by the staff team. At the time of inspection inspectors noted that one young person had been subject to three physical interventions to ensure safety. There was evidence of robust review of these events during SERG meetings with very clear points of learning which were communicated to the staff team. Another restrictive practice in place for a time for another young person was based on external clinical direction and had been subject to appropriate review. It was no longer required at the time of inspection.

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

Inspectors found that an open culture was promoted in the centre and staff that were interviewed were confident that they would challenge each other's practice if required.

There was evidence that the staff and management team were in regular contact and worked closely with social workers, advocates for young people and family members where appropriate. There were mechanisms in place for them to provide feedback on the care being provided and to identify areas of improvement. These took the form of surveys which were then reviewed at senior management level for learning and quality improvement purposes. Young people also gave feedback on the care they

received and all feedback was included in the services bi-annual quality report, the most recent of which was for the period January to June 2020.

The inspectors found that the centre had a written policy and procedure for the recording and notification of significant events. There was evidence that these notifications were sent in a timely manner to supervising social workers, young peoples' guardians ad litem, the organisation's psychologist and the Tusla National Private Placement Team. Inspectors noted that there was a section on the significant event template called '*action undertaken in response to this event and identify if further action is required*'. Inspectors found that this section consistently did not contain the required information to facilitate safe and effective planning. Review of management audits relating to communication evidenced a focus on whether documents were signed rather than an emphasis on the content, accuracy and quality of the records. Management must review the recording of significant events and ensure that all deficits are addressed.

Significant events were initially reviewed at local level with the people involved and this included staff debriefing. Following internal notification, the social care manager, regional manager and sometimes the client services manager raised queries, made comments or points of learning on the record. Significant events were also reviewed at team meetings, during staff supervision and in management meetings. There was evidence that feedback and learning outcomes were communicated to the staff team. There was a significant event review group (SERG) which was convened to review incidents with a risk rating of 15 or above or for re-occurring incidents. While there was evidence that this was a comprehensive process resulting in learning outcomes inspectors found that they did not always take place in line with policy. There were incidents where an SERG meeting should have been convened to review events but these did not occur. Supervising social workers interviewed by the inspectors confirmed that they were promptly notified of all significant events concerning their young people.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Standard 3.2** **Standard 3.3**
Practices did not meet the required standard	**Not all standards were assessed**

Actions required

- The client services manager must ensure that each young person has an up to date therapeutic plan to support the staff team to manage young people's issues that may influence their behaviour.
- The client services manager must ensure that there is clinical guidance and direction to the staff team and that this is evidenced on each young person's care record.
- The client services manager must ensure that there is a review of recording of information in the centre. They must ensure that records are accurate and contain all relevant information to facilitate safe and effective planning for young people.
- The client services manager must ensure that audits in the centre place a focus on the content, quality and accuracy of information in records.
- The client services manager must ensure that the handover process is reviewed to ensure all relevant information is properly recorded and communicated effectively to enable safe planning for young people.
- The client services manager must ensure that SERG meetings are convened in a timely manner in line with centre policy.

Regulation 5 Care Practices and Operational Policies
Regulation 6 (1 and 2) 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-cantered, safe and effective care and support.

There was a governance system in place and clearly defined lines of authority and responsibility. Each person had a job description and was clear in respect of their roles and responsibilities. A qualified and experienced centre manager was appointed to this centre in April 2019. They were employed for the past six years and had worked as a manager in another centre within this organisation. From the questionnaires and interviews with staff and review of centre files it was evident that the centre manager demonstrated good leadership and support. This was also confirmed by all supervising social workers. The centre manager reported to a regional manager who was responsible for four centres in the region. They in turn reported to the client services manager. Management meetings took place weekly and a review of the records evidenced that they reviewed planning for young people, operations, risk, health and safety, complaints and child protection, staffing, training and quality assurance. As noted above, inspectors found that there was delay in addressing deficits highlighted in respect of therapeutic plans as identified at these management meetings.

A review of records, interviews with internal staff and external professionals evidenced that there was a culture of learning and quality within the centre. There was evidence of a focus on the safety of young people and this was confirmed by all social work departments. However, inspectors found deficits in respect of records and communication following a significant event after which one young person died. The client services manager informed inspectors that an external review was taking place to establish if there were failings in care practice and governance and that the organisation would co-operate fully with the process. The client services manager must ensure there is an urgent review of recording and communication systems. They had altered some of their communication systems relating to checks of young people immediately after this young person's death. All social workers had visited their young people in the centre following the death of their peer and they informed inspectors they were satisfied with the follow up with young people after this

traumatic event. They stated that they felt that the centre could continue to keep their young person safe and address the goals of their care plans.

The centre manager confirmed that a service level agreement was in place with the funding body Tusla. Regular reports were provided to national placement team.

The centre had risk management policies and procedures in place for the identification, assessment and management of risk. There was a risk management framework in place and training had been provided relating to the matrix and its application in the centre. Inspectors found that staff were familiar with the policy and were utilising the framework in practice in the centre. Preadmission risk assessments had been carried out prior to the young people's admission and social workers confirmed that they were consulted as part of this process. Review of all young people's files showed evidence of individual risks being assessed and reviewed on an on-going basis with subsequent re-rating on the risk register if required.

There was a risk register in place which included organisational and individual risks. There was evidence that it was reviewed and updated regularly and it was discussed at management meetings.

The centre had a management structure appropriate to its size and purpose and function. There were arrangements in place to provide adequate managerial cover when the manager took periods of leave. Where managerial responsibilities were delegated to other staff members and a formal record of this was in place as required. There was an on call policy in place to guide, support and direct staff in the absence of the centre manager.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1** **Regulation 5**
Regulation not met	**None identified**

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

Actions required

- The client services manager must ensure that actions arising from management meetings are addressed in a timely manner.
- The client services manager must ensure there is an urgent review of recording and communication systems.

Regulations 6 Person in Charge
Regulation 7 Staffing

Theme 6: Responsive Workforce

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

Inspectors found that there were sufficient numbers of staff to meet the needs of young people and provide child centred and effective care. Social workers who were interviewed during inspection stated that while it was busy there were enough staff available on a daily basis and their young people had developed strong relationships with the keyworkers and the staff team. The client services manager stated that extra staff would be provided if required and inspectors found that this had happened in the months prior to inspection.

The staff team comprised of the social care manager, deputy manager, two social care leaders and five social care workers who held appropriate qualifications in social care. There were three staff members who were employed as trainees and were not qualified to a minimum level 7 and above in social care or a relevant equivalent course. One of these was in the process of completing a social care qualification but the other two (who worked part-time) were not currently studying to attain a relevant qualification. This was despite the organisation providing financial and other supports to unqualified staff. These staff were employed prior to the *Memo to Providers of Children's Residential Centres regarding Children's Residential Centres Staffing Levels and Staff Qualifications Requirements* being issued by the Alternative Care Inspection and Monitoring Service on 26th February 2020.

There have been improvements in the balance of qualified to unqualified staff since the last inspection in April/May 2019 when only two social care workers were qualified to the required standard. This must remain a focus for management to ensure all staff are qualified to an appropriate level.

The organisation had an appropriate focus on workforce planning and there were sufficient numbers of relief staff to cover periods of annual leave or sick leave. Inspectors found that young people were cared for in as much as possible by people who knew them and that they were familiar with. There was no use of agency staff members.

There was a policy and measures in place to promote staff retention and continuity of care for young people. Staff exit interviews took place and information from these was included in the services quality report and informed approaches to recruitment and retention of staff. Senior management reported that these measures had made a positive impact on staff stability in the centre.

The staff roster took account of the skills and experience on the team. There was an on call system in place which adequately provided for support and cover during evenings and weekends. There were detailed records of on-call interactions and decisions made for review and oversight purposes.

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

There was evidence that there was a focus on continuous professional development in the centre. With the exception of one staff member who commenced work in the centre just prior to the Covid 19 Pandemic, all staff had received training in the care framework in use across the organisation. Training was provided in child protection, a recognised model of behaviour management, first aid and fire safety. The management team had taken steps to ensure there was an awareness of recently revised organisational policies and procedures, relevant legislation and national standards among the staff team. Policies were regularly reviewed at team meetings. There was a training needs analysis and a resourced training plan in place for the coming year. Staff were supported and expected to attend scheduled training and there were resources available for external training. Required refresher training took place within the stated timeframes. The organisation had a pool of in-house trainers in support of the staff development programme and a wide range of supplementary training was provided in support of the work. These included drug awareness, the care framework, risk management, placement planning and keyworking, food safety and medication management and disordered eating amongst others. Five staff had

completed either ASIST or SAFE TALK suicide awareness training and three had completed STORM; skills based suicide prevention and self-injury mitigation.

There was a policy in respect of new staff being inducted to work in the organisation and the centre. This was evidenced as having been completed on individual personnel files. New staff completed shadow shifts with experienced members of the team before starting full time. Each staff member had an individual training and development plan which was reviewed in their professional supervision and annual staff appraisals had commenced recently. A database was in place to record and track all training and professional development.

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

Compliance with standards	
Practices met the required standard	**Standard 6.4**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards were assessed**

Actions required

- The client services manager must ensure that every effort is made to ensure all staff are qualified to an appropriate level.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The client services manager (CSM) must ensure that each young person has an up to date therapeutic plan to support the staff team to manage young people's issues that may influence their behaviour.	All therapeutic plans for young people have been completed	Changes have been made to the coordination of clinical resources to services. A weekly meeting will take place between the CSM and the clinical department with a fixed agenda item to include review of therapeutic plans. A scheduled monthly meeting is now in place where CSM, regional manager (RM) and unit manager (UM) will meet with the psychologist to review therapeutic plans. Input will be sought from the keyworkers for young people as to how effective the therapeutic plans are to staff as guiding documents to support them in their work with young people. The therapeutic plan will be a working document subject to on-going review. A new appointment has been made to the clinical team. The post holder is board certified holding a Doctorate as a

			behavioural analyst. They will join the team on the 26th of October in a part time capacity and will focus solely on developing Behaviour Support Plans (BSPs) for young people.
	The client services manager must ensure that there is clinical guidance and direction to the staff team and that this is evidenced on each young person's care record.	Whilst there has been on-going contact between the clinical department and centre management it is acknowledged that the minutes of these meetings and hence recorded information that would have offered more guidance and direction to the staff team was not evidenced. An administrative staff member has been assigned to the clinical department to ensure that records emanating from the clinical meetings are distributed and uploaded to the electronic record management system in a timely manner. This will be also evidenced in young people's care	There have been changes to the co-ordination of clinical resources to services. There will be weekly CSM/clinical meetings and monthly CSM/RM/UM/clinical meetings with input from young people's keyworkers. A fixed item agenda will be a review of the electronic record management system documents relating to clinical guidance and direction to the staff team and the recording of information in young people's files. The focus now will not be in the monthly meetings between clinical and service but on the therapeutic plan and the training of the plan and implementation of care framework.

		files.	
	The client services manager must ensure that there is a review of recording of information in the centre. They must ensure that records are accurate and contain all relevant information to facilitate safe and effective planning for young people.	A new RM daily risk review and governance report has been created on the electronic record management system. This includes a section on incidents and a sub section relating to actions competed/required as a result of an incident.	The report includes a CSM comment and oversight section. This will ensure that there is on-going review of the recording of information in the centre. In addition, more KPI's from the childcare department in terms of quality and risk have been added to the Senior Management Team (SMT) monthly dashboard. The deputy manager's admin hours are now more structured with a daily task list assigned.
	The client services manager must ensure that audits in the centre place a focus on the content, quality and accuracy of information in records.	The RM audit has been revised and is based on auditing against the 8 themes in the National Standards for Children's Residential Centres (HIQA). This is more qualitative than quantitative and includes more focus on the content, quality and accuracy of information in records.	The RM audits will be reviewed as part of regional reviews meetings between CSM and RM. This will be incorporated into the electronic record management system by mid November 2020. The new deputy manager audit and task list has already come into effect in October. A review of these systems will take place in December 2020 to measure the impact on quality.

	The client services manager must ensure that the handover process is reviewed to ensure all relevant information is properly recorded and communicated effectively to enable safe planning for young people.	A new handover document has been created on the electronic record management system which will allow for external managers to remotely view the handover rather than reliance on an internal hand written document. The Individual Risk Management Plan (IRMP) for each young person will be reviewed as part of the daily handover document.	The RM daily risk review and governance report includes a section on the handover process. As it is now an online document the Regional Manager can review the process. This process will also include oversight and commentary by the CSM.
	The client services manager must ensure that SERG meetings are convened in a timely manner in line with centre policy.	The new RM daily risk review and governance report includes a section on incidents and a sub section on incidents and whether a SERG review is required	The RM daily risk review and governance report includes a CSM comment and oversight section. Any requirements for a SERG review will be communicated to CSM through this forum which will ensure that SERG meetings will be convened in a timely manner.
5	The client services manager must ensure that actions arising from management meetings are addressed in a timely	A working group representing unit managers has been established were any future issues regarding	All issues or requests emanating from the monthly unit managers working group/SMT meeting will be responded to

	manner.	actions arising from management meetings can be addressed. This working group will have monthly scheduled meeting with the senior management team.	in a timely manner
	The client services manager must ensure there is an urgent review of recording and communication systems.	Changes have been made to the coordination of Clinical resources to services to include: -RM daily risk review and governance report -Review of IRMP's part of the daily handover. -A new handover document which can be accessed remotely by SMT -A UM/SMT working group	We promote a culture of openness and transparency and continuous improvement. This includes a commitment to on-going review of all systems including recording and communication systems.
6	The client services manager must ensure that every effort is made to ensure all staff are qualified to an appropriate level	The organisations' educational assistance programme has been offered and continues to be available to the two-part time staff who are not qualified to an appropriate level.	Only qualified staff will be appointed as social care workers in the centre.