An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 141

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Brighter Futures for Children Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced themed inspection**
Date of inspection:	**4th, 5th and 6th May 2021**
Registration Status:	**Registered from 8th August 2021 to 8th August 2024**
Inspection Team:	**Lorna Wogan** **Linda McGuinness**
Date Report Issued:	**11th August 2021**

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 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 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 08th August 2018. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from 08th August 2018 to the 08th August 2021.

The centre was registered to accommodate two young people (girls and boys) from age thirteen to seventeen years on admission. The overall aim of the centre was to provide residential care to vulnerable young people and an open, transparent person-centred service with a therapeutic approach. The centre's objective was to provide a safe and structured residential environment with a high level of support guided by the Three Pillars of Transforming Care, a model which was based on three elements - safety, connections and coping. The care approach was based on emotional containment and positive reinforcement to assist young people to develop internal controls of behaviour to promote resilience and responsibility. The centre's aim was to create a warm and caring environment where young people could come to terms with their past and prepare for the future.

There was one child living in the centre at the time of the inspection. The centre was granted a derogation to accommodate this child as they were under thirteen years on admission, which was outside of the centre's statement of purpose.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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 via teleconference 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 on the 12th July 2021 and to the relevant social work departments on the 12th July 2021. 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 26th July 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 141 without attached conditions from the 08th August 2021 to the 08th August 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practice s and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The inspectors found that the service had developed several new policies and procedures to meet the requirements of the National Standards for Children's Residential Centre's 2018 (HIQA). However, following a review by the inspectors of a number of operational policies relevant to this themed inspection the written policies were not sufficiently up to date or in line with current practice. They referenced the former national standards and did not refer to new and existing legislation and national policy as relevant to the service. The policy and procedure on protected disclosures must be updated to ensure there were safe and robust written procedures in place for raising concerns about poor care practices as well as a process for raising concerns about the wider operation of the service. The policy must also reassure staff that they can raise such concerns without fear of adverse consequences to themselves. Additionally, the staff recruitment policy must be updated to include the relevant vetting legislation, the requirements for overseas vetting and the procedure in place to deal with specified information or convictions that may be disclosed in the vetting process in relation to an applicant seeking employment. There was evidence on file that Garda vetting had been updated for staff since they commenced employment within the organisation however the written policy did not outline the timeframe for updating Garda vetting for employees.

The inspectors found that the timeframes for conducting statutory reviews for children placed in residential care aged 12 years and under was not adhered to or in line with the requirements of national protocol. The child in care statutory reviews for the child in placement had reverted to the six monthly regulatory timeframes when the child reached twelve years of age earlier this year. Following an interview with the social workers the inspectors found that the requirement of the national protocol was misinterpreted by the social work department and the centre manager.

The social workers and the centre manager must ensure that the monthly statutory reviews recommence until the child reaches thirteen years of age.

The inspectors found that staff had a good working knowledge of Children First National Guidance for the Protection and Welfare of Children, 2017 in relation to the identification, reporting and management of child protection and welfare concerns. Staff were aware that the centre manager was the designated liaison person and the person on-call was the deputy designated liaison person. Staff displayed an understanding of their role and responsibilities as mandated persons. Child safeguarding was discussed at team meetings and in supervision and this was evidenced in the records reviewed by the inspectors. All staff had completed the required Tulsa Children First *e*-learning programme. The inspectors were satisfied that the external governance and quality assurance manager was alert to risk of abuse and harm and was proactive to respond promptly and appropriately to any identified concern or potential risk of harm. However, following a review of the centre's child safeguarding policy document the inspectors found it was not sufficiently comprehensive and did not include all the required elements to ensure full compliance with the Children First Act 2015 and Children First National Guidance for the Protection and Welfare of Children, 2017. The centre's designated liaison person and the deputy designated liaison person must also be identified on the child safeguarding policy. The registered provider must ensure this policy is developed in line with the Tusla Guidance for Developing a Child Safeguarding Policy and Procedures (2nd edition).

The centre's child safeguarding statement was updated in 2021 as required and outlined the potential risks of harm or abuse for children living in the centre. Child sexual exploitation was included on updated child safeguarding statement and all staff interviewed were aware of the new Tusla guidelines for reporting concerns in relation to child sexual exploitation. Staff interviewed knew where the statement was located in the centre and were familiar with the risks identified on this document and the mitigation measures in place to reduce identified risks. The registered proprietor was named as the relevant person on the child safeguarding statement.

The centre had a designated child safeguarding officer who had a lead role to inform staff of new guidance and protocols regarding child protection and child welfare. There was evidence that the staff team had commenced a review of child safeguarding policies, procedures and practice in staff meetings and in supervision and staff interviewed were able to discuss with the inspectors key safeguarding policies and practices in place with particular reference to the current child in placement.

Notwithstanding this the registered proprietor must ensure that the practice on the ground is supported by a clear, accurate and comprehensive suite of written policies and procedures.

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The appointed person in charge resigned from their post at the end of March 2021. The registered provider notified Tusla's alternative care inspection and monitoring service of the change of person in charge of the centre in compliance with the regulations. The recruitment process for a new person in charge was well advanced at the time of the inspection. In the interim the registered proprietor was based at the centre and had taken on the managerial role and responsibilities of the person in charge. The registered proprietor was suitably qualified and experienced to undertake this role.

There was a formal system established to undertake management meetings to ensure that the residential centre had effective leadership, governance and oversight systems in place. These meetings were scheduled on a monthly basis up until March 2021 when the person in charge left their role and were attended by the registered provider, the person in charge and the governance and quality assurance manager. The inspectors reviewed the minutes of these meetings up to March 2021. The minutes evidenced robust oversight of the management and governance of the centre. The management meeting between the registered proprietor and the governance and quality assurance manager in April 2021 was not on file at the time of the inspection. The registered proprietor must ensure the minutes of the April 2021 meeting is placed on the record and that all management meetings are clearly dated and signed by the relevant parties and are available for inspection. The registered proprietor confirmed the management meetings as formerly structured would resume when the new person in charge was appointed and commenced employment. Staff and managers interviewed stated that the former person in charge attended the daily handover meeting however there was no evidence on the handover records to evidence their attendance or their input in the handover meeting process. The person in charge must sign the handover meeting records and ensure any guidance or decision taken by them is evidenced.

Since the commencement of internal and external audits the inspectors found there was a culture of learning in the centre that supported improvements and the on-going development of safe care practices. However, the inspectors found there were deficits in the internal governance of the centre that were not identified by the external manager in a timely manner. These deficits were rectified at the time of the inspection. Deficits in the internal governance were identified following the appointment of the governance and quality assurance manager in December 2020 and were appropriately reported and addressed by the registered proprietor. This issue was acknowledged by the registered proprietor and clear learning outcomes were identified. The registered proprietor reviewed the whistle blowing policy with the staff team and had taken the necessary steps to rectify gaps in the governance systems. These learning outcomes were evidenced in management meetings where they were identified and discussed in an open and transparent manner. The inspectors were satisfied there was strong leadership and oversight of the centre practices at this time by the registered proprietor who was accessible to staff and on site most days. At the time of the inspection there was evidence that the registered provider, who was undertaking the role of the person in charge, provided the staff with clear guidance and direction and there was robust oversight of the centre's day-to-day practices. The staff interviewed were aware of the management and reporting procedures in place at this time and were able to describe the various roles and the responsibilities of staff, the managers and consultants both internally and externally in relation to the centre's operations.

The registered proprietor confirmed they were engaged with Tusla's national private placement team in relation to placement contracts and the procurement of services. The national private placement team had access to regulatory inspection reports, data on significant events and progress reports from social workers to inform them of the centre's compliance with the standards and relevant legislation and the child's progress in the placement.

The inspectors acknowledge that the registered proprietor was currently updating and reviewing the centre's suite of policies and procedures. The completion of this must be prioritised for action with a clear timeframe for completion to include a training plan for staff on the updated and newly developed policies.

There was a risk management framework in place and the centre maintained a risk management folder. Risks relating to behaviour that challenges were set out in an individual crisis management plan that was subject to regular review and update. Risks associated with unauthorised absences were set out in an absence management plan. Individual risks relating to the child's presentation were identified, risk rated

and control measures set out on the risk assessment. Risk assessments were signed by the person in charge and the staff completing the risk assessment. There was a sign off system in place to evidence that all staff had read the risk assessments on file. There was evidence that risks were reviewed every three months and discussed at team meetings and updated as appropriate. Risk registers were reviewed by the governance and quality assurance manager. Centre-based risks and environmental risks were also maintained on file.

When on site the inspectors noted there was a stream at the rear of the premises. The registered proprietor must undertake a risk assessment in relation to this stream and implement appropriate safety measures to ensure it does not pose any risk to the safety of the child in placement.

There was an appropriate system in place for on-call outside of office hours and at weekends. Staff stated it was an effective, beneficial support. The written policy provided guidance on the use of the on-call service and that on-call contact, advice and guidance should be recorded. The inspectors were informed that on-call advice and guidance was recorded on the significant event notification or in the centre's communication book. The inspectors recommend that records of on-call activity should be input on the shared electronic record management system to ensure on-call staff can access it and review any previous guidance provided and record the guidance which they provided when on-call.

There was an internal management structure appropriate to the size and purpose and function of the centre. There were three social care leaders within the team that supported and led the practice in the centre. However, there was a pattern whereby the registered proprietor covered the role of the person in charge when they were absent from the centre or filled gaps in the staff rota where required. The inspector's recommend that the registered proprietor further develop the internal management structure to ensure that alternative management arrangements are in place for when the person in charge is absent from the centre.

The registered provider had not delegated any of the managerial tasks of the person in charge to other staff members at the time of the inspection. However, there was no system in place to maintain a written record of managerial tasks delegated to appropriately qualified staff members as required under the national standards. The registered provider must ensure there is a system in place to record managerial tasks delegated by the person in charge.

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre had a written statement of purpose that was updated in April 2021. The statement outlined the aims and objectives of the service, the cohort of young people it catered for and the model of care and approach to working with young people. It set out the management and staffing structure for the centre. The use of consultants with specific expertise that supported the model of care and the therapeutic approach should be incorporated into the statement and the statement must identify the person/s that reviewed and approved the document. Inspectors noted that the statement referenced the incorrect legislation stating it operated in line with Child Care (Placement of Children in Residential Care) Regulations 1995 however all non-statutory residential centres are regulated and operate under the Child Care (Standards in Residential Care) Regulations, 1996.

Staff were familiar with the model of care and had received informal training from the former person in charge who was appropriately trained to deliver this training. There was evidence that the staff discussed the centre's model of care in supervision and one of the social care leaders undertook a presentation on the model of care for staff at a team meeting. The registered provider had also tasked each staff member to undertake a written exercise to outline their understanding of the model of care. Staff interviewed displayed a good working knowledge of the model of care and the therapeutic approach to working with the child in placement. There was evidence of the application of the model of care across centre records reviewed by the inspectors. The inspectors found that the child in placement was responding well to the care approach and was making progress in their placement. There was a plan in place to provide more formal training for staff on their attachment based approach. There was good clinical oversight of the therapeutic care approach by the external consultants and the external specialists involved in the child's care. There was good oversight of the model of care by the registered provider and the quality assurance manager through supervision, attendance at team meetings and oversight of the centre records.

There was a young person's information booklet that was made available to young people and that outlined the purpose of the centre and the expectations in relation to day-to-day living. Overall inspectors found it was a comprehensive, welcoming, accessible booklet.

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.

The inspectors were satisfied that at the time of the inspection there were appropriate systems in place to assess the safety and quality of care provided in the centre against the national standards. Audits completed to date by the governance and quality assurance manager evidenced that the quality and safety of the care was being assessed in a systematic and planned manner for the year ahead. The registered proprietor must ensure they respond to recommendations arising from these audits in a timely manner and where the required actions cannot be met within the specified timeframes this must to be noted on the audit action plan. The quality assurance manager must ensure that all audits are signed, dated and that they evidence who they are forwarded to for action/response.

The inspectors found evidence of reviews of the quality, safety and continuity of care provided to the child by the registered provider and the governance and quality assurance manager. There was good oversight of centre records and clear guidance provided to the staff team collectively and individually.

The centre had a written complaints policy and procedure and staff interviewed were familiar with the complaints procedure. As with other written policies the complaints policy must be reviewed and updated in line with new legislation and best practice in complaints resolution to include information on the Tusla complaint procedure 'Tell Us'. The complaints policy must also be updated to include information on how the service monitors and analyses complaints to promote improvements. Complaints should also be a standing item on the team meeting agenda for review and identification of learning outcomes following complaints investigation. The complaints register and supporting complaints records were reviewed by the inspectors. There was one additional complaint recorded on the register since the last inspection in December 2020. The centre's complaint register must evidence if the complaint was upheld or not upheld. Following the review of a recent complaint the inspectors recommend that the quality assurance manager undertake a review of the daily logs and other relevant centre records to ensure there are no additional practices of concern that should have been managed through the complaints process that may have been previously missed.

There was evidence that the staff were expected to review and identify learning from issues, concerns and complaints and use these incidents as opportunities to improve practice. There was evidence that this culture of learning was being embedded in the

team and staff confirmed that practice issues raised by the managers were always constructive and beneficial.

The inspectors were provided with a copy of the centre's annual compliance report and service improvement plan which was completed by the former person in charge. The annual report was due to be completed in November 2020 however was not completed until February 2021. While the annual report did refer to the outcome of regulatory inspections and actions taken to address identified deficits overall the inspectors found that the report was not sufficient to meet the requirements of the national standards. The report as it was structured focused solely on some specific areas of practice and did not contain commentary on compliance across all of the national standards. The annual report did not report on the operation of the centre against its own objectives, purpose and function. The registered provider stated that audits completed by the governance and quality assurance manager throughout the coming year would provide comprehensive information on the centre's compliance with the national standards and the centre's objectives for the annual review of compliance at the end of 2021.

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

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 5.2** **Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**Standard 5.1**

Actions required

- The registered provider must ensure that the centres suite of policies and procedures are updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA.
- The registered provider must ensure the centres child safeguarding policy is developed in line with the Tusla Guidance for Developing a Child Safeguarding Policy and Procedures (2nd edition).

- The social work department and the centre manager must ensure that the monthly statutory reviews recommence in line with the national protocol for the review of children aged 12 years and under in residential care.
- The person in charge must sign the handover meeting records and ensure any guidance or decision taken by them is evidenced on the meeting record.
- The registered proprietor must undertake a risk assessment on a stream at the back of the premises and implement appropriate safety measures to ensure it does not pose any risk to the safety of the child in placement.
- The registered provider must ensure there is a system in place to record managerial tasks delegated by the person in charge.
- The registered proprietor must include the range of services and specialised supports provided in the centre in their statement of purpose. The statement must also identify the person/s that reviewed and approved the document.
- The registered proprietor must ensure they respond to recommendations arising from the quality audits in a timely manner and where the required actions cannot be met within the specified timeframes this must to be noted on the audit action plan. The quality assurance manager must ensure that all audits are signed, dated and evidence who they are forwarded to for action/response.
- The registered provider must ensure the complaints policy is updated in line with new legislation and best practice in complaints resolution to include information on the Tusla complaint procedure 'Tell Us'. The policy must also be updated to include information on how the service monitors and analyses complaints to promote improvements.
- The registered provider must ensure that complaints are a standing item on the team meeting agenda for review and identification of learning outcomes following complaints investigation.
- The quality assurance manager must undertake a review of the daily logs and other relevant centre records to ensure there are no additional practices of concern that should have been managed through the complaints process that may have been previously missed.
- The registered provider must ensure that the annual review of compliance for 2021 meets the requirements of the national standards and provides comprehensive information on the centre's compliance with the national standards and the centre's objectives and sets out an improvement plan for the year ahead.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider must ensure that the centres suite of policies and procedures are updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA).	The registered centres suite of policies and procedures are currently being updated by the registered proprietor, in line with the National Standards for Children's Residential Centres, 2018 (HIQA). Completion date - 30th September 2021	The registered centres suite of policies and procedures will be reviewed by the registered proprietor on a 6-month cycle to ensure they remain in line with the National Standards for Children's Residential Centres, 2018 (HIQA).
	The registered provider must ensure the centres child safeguarding policy is developed in line with the Tusla Guidance for Developing a Child Safeguarding Policy and Procedures (2nd edition).	The centres child safeguarding policy is currently being developed by the registered proprietor in line with the Tusla Guidance for Developing a Child Safeguarding Policy and Procedures (2nd edition). Completion date – 30 September 2021	The centres child safeguarding policy will be reviewed by the registered proprietor on a 6-month cycle to ensure they remain in line with the Tusla Guidance for Developing a Child Safeguarding Policy and Procedures (2nd edition).
	The social work department and the centre manager must ensure that the monthly statutory reviews recommence in line with	Following clarification from Tusla Inspectors, the statutory Child in Care Review meetings have been reinstated in line with the national protocol for the	The social work department and centre manager are committed to ensuring the statutory Child in Care Review meetings will continue until the child is 13 years of age.

	the national protocol for the review of children aged 12 years and under in residential care.	review of children aged 12 years and under in residential care. Time Scale - This action has been implemented with immediate effect.	
	The person in charge must sign the handover meeting records and ensure any guidance or decision taken by them is evidenced on the meeting record.	The person in charge (centre manager) regularly attends the handover meetings. The registered proprietor has instructed that the handover meeting records are now signed by the centre manager daily and the centre manager's guidance and/or decisions are recorded on the handover meetings records. Time Scale - This action has been implemented with immediate effect.	This task has been written into the centre manager's daily work schedule. Verification of completion will be sought during the centre manager's monthly supervision and during Management Meetings. The records will also be subject to examination by the Quality Assurance and Governance Manager.
	The registered proprietor must undertake a risk assessment on a stream at the back of the premises and implement appropriate safety measures to ensure it does not pose any risk to the safety of the child in placement.	A Health & Safety Inspector from our HR Consultants conducted a thorough and detailed risk assessment of the centre property and did not raise any concerns about danger posed to the child by the stream. However, the Proprietor will instruct their HR Consultants to carry out a specific risk assessment to identify any/all potential risk posed to the child by the existence of the stream. Completion	The registered proprietor will implement any action recommended by the Health & Safety Inspector to ensure the child is not at risk from the existence and locality of the stream.

		Date – By 31st August 2021.	
	The registered provider must ensure there is a system in place to record managerial tasks delegated by the person in charge.	Managerial tasks delegated by the centre manager to Team Leaders have been recorded during a Team Leaders Meeting. Time Scale - This action has been implemented with immediate effect.	The centre manager attends the monthly Team Leaders Meetings regularly to ensure delegated tasks are being completed.
	The registered proprietor must include the range of services and specialised supports provided in the centre in their statement of purpose. The statement must also identify the person/s that reviewed and approved the document.	The registered proprietor is currently updating the statement of purpose to include the range of services and specialised supports provided in the centre. The statement will identify the person that reviewed and approved the document. Completion date – 31st August 2021	The centres statement of purpose will be reviewed by the registered proprietor on a 6-month cycle to ensure it correctly details the range of services and specialised services provided in the centre. The updated statement of purpose will detail the person that reviewed and approved the document.
	The registered proprietor must ensure they respond to recommendations arising from the quality audits in a timely manner and where the required actions cannot be met within the specified timeframes this must be noted on the audit action plan. The quality assurance	The registered proprietor will agree with the Quality Assurance & Governance Manager a timescale for the completion of recommendations. This action is in recognition that the timescale for the completion of recommendations will differ. Time Scale - This action has been implemented with immediate effect.	The registered proprietor will meet with the Quality Assurance & Governance Manager within one week of the production of the audit report to allocate and record timescales for the completion of recommendations.

	manager must ensure that all audits are signed, dated and evidence who they are forwarded to for action/response.		
	The registered provider must ensure the complaints policy is updated in line with new legislation and best practice in complaints resolution to include information on the Tusla complaint procedure 'Tell Us'. The policy must also be updated to include information on how the service monitors and analyses complaints to promote improvements.	The registered provider is currently updating the centres complaints policy in line with new legislation and best practice in complaints resolution. The policy will include information on the Tusla complaint procedure 'Tell Us'. The policy will also detail how the service monitors and analyses complaints to promote improvements. Completion date – 31st August 2021	The centres complaints policy will be reviewed by the registered proprietor on a 6-month cycle to ensure it remains in line with new legislation and best practice in complaints resolution and includes information on the Tusla complaint procedure 'Tell Us.'
	The registered provider must ensure that complaints are a standing item on the team meeting agenda for review and identification of learning outcomes following complaints	The registered provider has included complaints as a standing item on the team meeting agenda for review and identification of learning outcomes following complaints investigation. Time Scale - This action has been	The registered provider will ensure complaints remain a standing item on the team meeting agenda and that complaints are reviewed for the identification of learning outcomes following complaints investigation.

	investigation. The quality assurance manager must undertake a review of the daily logs and other relevant centre records to ensure there are no additional practices of concern that should have been managed through the complaints process that may have been previously missed.	implemented with immediate effect. The quality assurance manager has completed a review of relevant centre records and all daily logs – completed on 13.05.21. All findings have been forwarded to centre manager/Director. A review of the complaints process was discussed during a team meeting with all staff members and findings discussed. All findings in relation to complaints have been addressed by staff/keyworkers. All staff have been informed of how to respond appropriately to complaints made by the child. Time Scale - This action has been completed.	Appointment of governance manager in January 2021. Governance manager completes monthly audits and attends team meetings. Complaints remain a standing item on the team meeting agenda and is discussed with all staff members fortnightly. The child is offered a complaints form in relation to all complaints made.
	The registered provider must ensure that the annual review of compliance for 2021 meets the requirements of the national standards and provides comprehensive information on the centre's compliance with the national standards and the	The annual review of compliance will be completed by the Quality Assurance & Governance manager in December 2021. The director will oversee the annual review of compliance and ensure the completed document meets the requirement of the national standards. The Quality Assurance & Governance manager and the director	The compliance improvement plan will be monitored throughout the year during audits completed by the Quality Assurance & Governance manager. The improvement plan will be a standing item during the fortnightly Management Meetings that are chaired by the director.

	centre's objectives and sets out an improvement plan for the year ahead.	will ensure an improvement plan is implemented for the year ahead. Time Scale – December 2021.	