



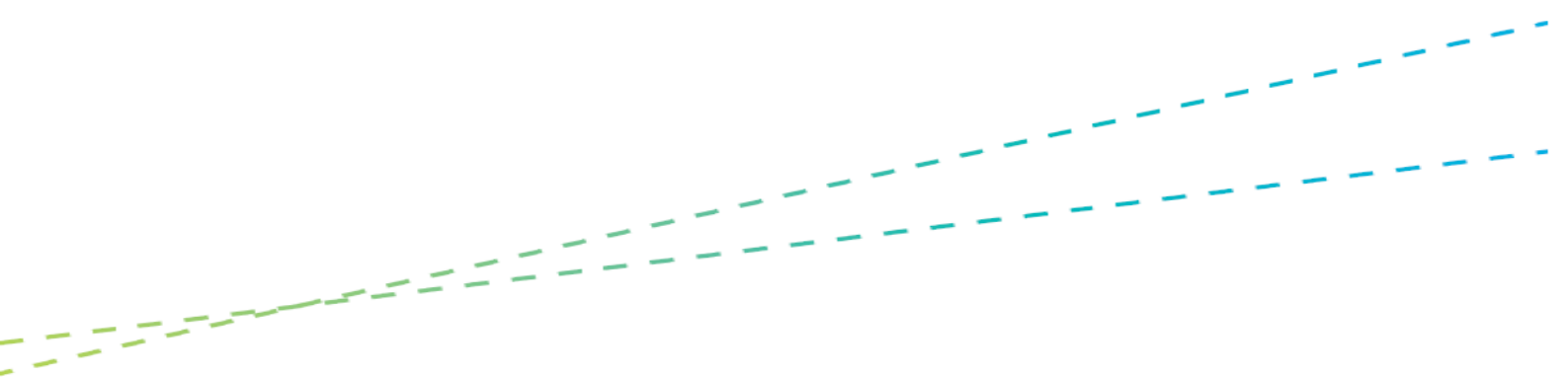
An Ghníomhaireacht um  
Leanaí agus an Teaghlach  
Child and Family Agency

## Alternative Care - Inspection and Monitoring Service

### Children's Residential Centre

**Centre ID number: 286**

**Year: 2025**



## Inspection Report

<b>Year:</b>	<b>2025</b>
<b>Name of Organisation:</b>	<b>Care Ireland</b>
<b>Registered Capacity:</b>	<b>Seven young people</b>
<b>Type of Inspection:</b>	<b>Announced</b>
<b>Date of inspection:</b>	<b>29<sup>th</sup> &amp; 30<sup>th</sup> October 2025</b>
<b>Registration Status:</b>	<b>Registered from the 7<sup>th</sup> of March 2025 to the 7<sup>th</sup> of March 2028</b>
<b>Inspection Team:</b>	<b>Catherine Hanly Cora Kelly</b>
<b>Date Report Issued:</b>	<b>21<sup>st</sup> April 2026</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 7<sup>th</sup> of March 2025. At the time of this inspection the centre was in its first registration and was in year one of the cycle.

The centre was registered as a multi-occupancy service for young people thought to be aged between 16 and 17 years. It aimed to provide high quality primary care in a safe, comfortable home environment, for up to a maximum of seven age-disputed young people, with realistic expectations of their holistic development and behaviour within predictable boundaries. The intended length of stay was short term, extending to a maximum of six months. There had been more than eighty admissions since the centre opened, with most young people staying in the centre for less than one month. There were seven young people living in the centre at the time of the inspection, all of whom were in an age-disputed assessment process at that time.

## 1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2

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, two senior managers in Tusla with responsibility for commissioning and oversight of this age-disputed service. One young person in residence met with inspectors to discuss their experience of living in the centre. 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 25<sup>th</sup> of November 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. In the period following the onsite visit to the centre and the draft report being issued, a new centre manager had been appointed in mid-November. This manager returned the report with a CAPA on the 19<sup>th</sup> of December 2025. This was deemed to be satisfactory overall, however several matters required confirmation from the registered proprietor. These were identified to the centre manager and registered proprietor and a response requested.

On the 2<sup>nd</sup> of January 2026, the Alternative Care Inspection and Monitoring Team (ACIMS) received correspondence from the registered proprietor informing them of another change in manager of the centre and seeking to appoint a replacement for the person that had been appointed in mid-November. The lead inspector again wrote to the registered proprietor on the 5<sup>th</sup> of January seeking confirmation of outstanding matters in the CAPA submitted. The registered proprietor submitted a CAPA on the 14<sup>th</sup> of January 2026. This content of this CAPA was different to the one previously submitted and was not deemed to be satisfactory as it did not respond to all actions named in the inspection report, nor did it provide sufficient clarity on actions taken/to be taken in response to deficits identified. This finding was outlined to the registered proprietor and a full response requested to be submitted by the 19<sup>th</sup> of January 2026. Meeting convened February 3<sup>rd</sup> with the registered proprietor, the area manager and the newly appointed centre manager. Expectations were clearly outlined in this meeting and a response requested 13<sup>th</sup> February. Documents were submitted however the overall response was not deemed acceptable. The inspection manager met with the registered proprietor again on Thursday 19<sup>th</sup> February. Further documentation submitted 25<sup>th</sup> February was again deemed to require amendments. On the 5<sup>th</sup> of March 2026, the ACIMS accepted the CAPA submitted. The implementation of this CAPA will be assessed by the ACIMS within twelve weeks of this final inspection report being issued.

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: 286 without attached conditions from the 7<sup>th</sup> of March 2025 to the 7<sup>th</sup> of March 2028 pursuant to Part VIII, 1991 Child Care Act.

### 3. Inspection Findings

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

**Regulation 16: Notification of Significant Events**

**Theme 3: Safe Care and Support**

**Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.**

The centre had been operational over seven months at the time of this inspection. The registered proprietor had submitted a suite of policy documents at the point of registration and the centre manager informed inspectors that these had been adapted from a sister residential centre within the agency. The manager stated that these policies were reviewed at team meetings however records sampled by inspectors did not provide supporting evidence of this. Whilst the evidence of policy discussion was lacking in team meeting minutes reviewed, there was a recurring theme of safeguarding being discussed and staff also referenced in interview their responsibility to ensure the wellbeing and safety of young people whilst in placement. There were a range of policies and procedures within the overarching policy document that related to safeguarding and child protection, including policies and procedures on Child Protection and Welfare, Bullying and Child Protection, and a Policy on Disclosures and Allegations of Abuse amongst others. These policies were found to be largely in line with relevant legislation and Children First. However, immediate review is required to address anomalies found by inspectors in relation to policy and corresponding practice in the centre; and to ensure that the discussions at team meetings are fully informed and in line with Children First and relevant legislation.

The policy document named the centre manager as the designated liaison person (DLP), and they understood their associated role and responsibilities and had completed training for this role. The policy also referred to a deputy designated liaison person (DDL), however there was no one appointed to this role at the time of the inspection although a plan to appoint the newly commenced deputy manager was referenced. Centre management must ensure that the deputy DLP and anyone delegated this responsibility has completed the training. The policy document was conflicting in relation to mandated persons – it named all staff working at the centre as mandated persons and elsewhere named mandated persons as those with a qualification (non-specified), training (non-specified) and experience (length/type

not stated) which did not include all staff. Inspectors found that the team had different understandings of who on the team held the role of mandated persons, this should be clearly understood by all staff and must be addressed with the team and be clarified in policy. The list of named persons must be maintained at the centre. The policy document did not contain information on procedures to follow if a young person was the victim or suspected victim of child sexual exploitation or trafficking. The policy did not reference concerns relating to child protection that did not meet the threshold for reporting and what should happen with these concerns in terms of recording, tracking and reporting. These matters must be addressed and included in the policy review.

There was a child safeguarding statement (CSS) in place that had been developed in January 2025, prior to the centre opening. This was on display in the centre and team meeting records evidenced that it was highlighted to staff that they should be aware of and familiar with same. Inspectors found that in interview, some people struggled to name the risks contained within the CSS. It requires immediate review to include the risk of trafficking posed to this group of young people and to include a greater emphasis on child sexual exploitation (CSE) as a standalone risk. Some of the staff team had completed online training in Children First although there were some gaps in staff having completed the mandatory training module. Staff members had also completed training in Human Trafficking Awareness, and Child Sexual Exploitation, however not all staff had completed these. Centre management must attend to these gaps in training. There was no specific child protection completed. Once reviewed and amended, centre management must ensure that all staff have a thorough working knowledge of the application of all child protection and safeguarding policies and procedures for this service.

This centre was the first of its kind to be established as a residential service for age-disputed separated children seeking international protection (SCSIP). The manager and staff team demonstrated a clear understanding that all young people referred to them would be treated as a minor unless determined otherwise by the referring social work department. The service was operating on a temporary basis, since opening, in a terraced three-storey over lower ground floor building. It could accommodate seven young people in individual bedrooms. Three bedrooms were ensuite. A further two bedrooms were also ensuite but both rooms required cross-access via another bedroom to access the shared bathroom. Inspectors found that there were no additional safeguards such as risk assessments for each occasion of young people using these 'shared' bedrooms; no thorough assessment at point of referral regarding gender, ethnic, cultural or other background considerations prior to assigning these

'shared' rooms. Whilst there were two waking staff consistently on each night, with generally hourly checks of young people, the shared room situation was behind a closed door on different levels of the house. One young person previously placed in one of these rooms had stated that they felt unsafe and, for a period, the waking night staff had been situated outside their room. This situation requires immediate review, and a robust risk assessment must be implemented to determine factors to be considered when assigning young people to these rooms.

Pre-admission meetings were convened between various staff from the centre and the referring social work department. These took place remotely and inspectors found that the format and content of these meetings varied considerably. In general, very little information was known by the referring social work department about the young person being referred. The manager informed inspectors that a newly developed collective risk assessment (CRA) document had been devised and would be implemented to inform this process and to ensure that admission decisions were made in consideration of all known information. The implementation of these CRAs should assist in consolidating the little information available and planning around this. The centre manager must review the CRA and the supporting assessment tool as there are discrepancies in the structure of the latter. Inspectors viewed records of pre-admission meetings where it was identified that the young person's level of English was low or not understood. In these instances, interpreters had not been used for the pre-admission meeting/young person's first introduction to the centre. Records reviewed by inspectors showed that some young people had not understood the reasons for the level of supervision they had upon moving to this centre, particularly if they had been residing in another residential facility prior to their admission here. The young person inspectors spoke with stated that they had not received an information booklet on their admission, although staff stated this was not the case. Interpreters should be used at the point of admission to ensure each young person has a full understanding of their placement in this centre.

Inspectors reviewed a sample of individual work records as well as young people's meetings. These showed that staff were consistently having informative discussions with young people on topics such as safety in the community, life skills, children's rights, privacy, how to make a complaint, situations that were safe/unsafe and what to do in the latter, settling into and expectations whilst living in this centre. The young person inspectors spoke with described how very happy they were living there and how nice the staff were. Inspectors also observed warm and caring interactions between the staff and young people on the day of their visit. Where a young person's mental health had presented as a significant concern, staff had responded promptly

to ensure that young people were provided with the necessary medical intervention and treatment needed. More frequent checks of the young person had been implemented, following risk assessment, to ensure their continued safety in the placement. Hourly checks of young people were conducted by waking staff through the night as standard. The reason given for this was safety of the young person, but staff couldn't explain further as to what or why it was deemed to be unsafe. Better informed and more robust risk assessments upon admission should contribute to having a clear rationale for checks on young people at nighttime. Inspectors noted that information that may present as unusual or away from the young person's baseline that may be indicative of additional vulnerabilities, or indeed the reverse, were not being recorded and tracked. Such behaviours or presentations should be recorded and tracked in the interest of continuous safeguarding and should be appropriately reported to the social work department as necessary.

The centre had a policy on protected disclosures that identified the centre manager as the person to whom such a disclosure could be made. Staff understood the availability of the manager and the service director/registered proprietor to make such a report if necessary.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 5 Regulation 16</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 3.1</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- The registered proprietor must ensure that their policies and procedures regarding child protection and safeguarding comply with Children First and relevant legislation. This should include a list of mandated persons and a system for recording matters related to child protection that do not meet the threshold for reporting.
- Centre management must review and update their Child Safeguarding Statement (CSS) to include all potential risks relevant to the young people in this service. All management and staff must be familiar with their CSS.

- Centre management must provide a schedule of training to identify current gaps related to child protection and safeguarding.
- The use of shared bathrooms requires immediate review, and a robust risk assessment must be implemented to determine factors to be considered when assigning young people to these rooms. Additional safeguards must also be considered and implemented as necessary.
- Centre management must implement a system for recording matters related to child protection that do not meet the threshold for reporting. All staff should be familiar with this system.

### Regulation 5: Care Practices and Operational Policies

### Regulation 6: Person in Charge

### Theme 5: Leadership, Governance and Management

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

The named person in charge of this centre was a qualified and experienced manager that had been with the company for over ten years. They had previously worked as manager of another residential centre within this agency prior to being involved in the development of this service. Inspectors found that the manager was not as familiar with aspects connected to delivery of this service including the eligibility assessment for young people which is key given the age-disputed nature of the service. There were other areas related to the day-to-day delivery of the service including the content of the CSS, as well as staffing numbers and contracts, that the manager was not familiar with. The centre manager must ensure they are familiar with all aspects of the service that they have named responsibility for delivering. The manager was named by staff as available and supportive to them in their roles. Team meeting minutes reviewed evidenced their input and direction to the staff team also.

There was a deputy manager in place, they had been appointed approximately one month prior to this inspection and had significant experience in working in service provision for SCSIP. The plan outlined to inspectors was that the deputy would provide formal cover for the manager for any period of absence, including the role of deputy DLP once the training was completed. There were also three social care leaders in post with a mix of qualifications and experience. The manager had

delegated tasks to some of the social care leaders during periods of absence prior to the appointment of the deputy manager and records of delegated tasks were maintained. There had been no formal recruitment process for some internal promotions that had occurred. The registered proprietor must ensure that practices for recruitment and selection comply with their own stated “*rigorous recruitment and selection*” policy and consists of a formal interview process as a minimum for all posts advertised.

Governance arrangements in place included regular audits and monthly management meetings between the centre manager and service director. In the month since the deputy managers’ appointment, they had attended this meeting forum also. The centre manager was in regular contact with the service director outside of these mechanisms confirming their responsiveness to service-related matters arising. The audits reviewed by inspectors read as a tick box of tasks to be completed and were found to be repetitive month to month. The format of these would benefit from review to allow for more qualitative data to be gathered, analysed and reported on in the context of service delivery compliance with national standards and best practice.

The monthly meeting records had a standing agenda with staff matters, complaints, training needs, amongst others. Inspectors noted that actions identified in this forum were not consistently followed through and were not reviewed at the next meeting. Additional matters requiring attention from a governance perspective included some of the centre registers. The register of young people residing in the centre must be reviewed to ensure it includes the necessary and relevant information required to comply with the regulation. There were discrepancies between the column titles and the content within them. The complaints register did not include summary information on the nature of the complaints made and this would be useful information for oversight purposes in terms of tracking themes or patterns arising. The format of the daily log should be reviewed – currently the account of the young person’s day is listed under the heading ‘significant event’ and this should be changed so that it doesn’t become confused with an actual significant event requiring notification. Improvements and further development will be required in existing governance structures to ensure robust reporting relationships, effective and responsive oversight of service delivery and a focus on actions necessary for service improvement.

There was a service level agreement (SLA) in place between Tusla and the service provider. Inspectors were informed that a review of service provision was due to take place in the coming weeks. Inspectors recommended to the registered proprietor and

the Tusla area manager that clarification be sought regarding the eligibility-assessment process, the age-determination process, the language used around these mechanisms, and that information be provided to centre management on the discharge destination of young people when they move on from this centre.

There was a short policy with associated procedures on risk assessment in the centre. This policy and the attached procedures must be reviewed, expanded upon and centre management must ensure they are realised in practice. The development and inclusion of a risk matrix would be beneficial in terms of risk rating concerns and determining whether interventions were effective in reducing presenting risk. Inspectors found that there was some understanding of risk and the need to conduct risk assessments but as stated under standard 3.1 this needs to be expanded upon at pre-admission stage and in accordance with the centre's policy – implemented at the point of admission. Some pre-admission risk assessments were not completed until five days post-admission. The centre risk register was named as a live document but did not read as such in that it was difficult to ascertain from this record what risks remained live with accompanying risk assessments. Also, the risk register record only commenced in June and should have been in place from service commencement in March. Inspectors found that some risks detailed in individual records, for example a young person smoking in their bedroom, had not been added to the register. Inspectors found that the naming of the actual risk was unclear – the situation or behaviour or related topic was named, for example 'fire safety' – but the actual risk and to whom it presented was not made clear. Significant work is required to ensure that risk is appropriately assessed, responded to and managed in this centre.

As stated under standard 3.1 there was a suite of policy documents in place. The manager stated that these were due to be reviewed formally within the coming weeks with the registered proprietor. This review must take priority to ensure that all policies and procedures are in line with regulatory requirements, and that they take account of the national standards.

<b>Compliance with regulations</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 5.2</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- The registered proprietor must satisfy themselves that the centre manager is familiar with all aspects of the service and delivering effectively on all named responsibilities.
- The registered proprietor must ensure that practices for recruitment and selection comply with their own policy.
- The registered proprietor and centre management must undertake a review of the policy and accompanying procedures related to risk and ensure that the approach is robust and responsive.
- Centre management and the registered proprietor must commit to a full review of the suite of policy documents.

## 4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered proprietor must ensure that their policies and procedures regarding child protection and safeguarding comply with Children First and relevant legislation. This should include a list of mandated persons and a system for recording matters related to child protection that do not meet the threshold for reporting.	The registered provider, area manager and centre manager conducted a full review of all child protection and safeguarding policies to ensure alignment with Children First Act (2015) and other relevant legislation, regulations and standards. This review included identifying the mandated persons in the centre. A guidance document regarding mandated persons and non-mandated persons has been completed and circulated to all staff. The centre manager went through the Child Protection and Safeguarding policies with staff at their <b>team meeting on 11 February 2026</b> . Going forward, at each of the weekly team meetings, the centre manager will discuss one policy with the staff. Safeguarding policies is now a standing agenda item at the staff meeting.	An annual review of all safeguarding policies will take place, <b>starting August 2026</b> . Child protection and safeguarding is a standing agenda item at team meetings. The centre manager will complete quarterly audits of child protection records, including low-threshold concerns. The guidance document on mandated and non-mandated persons will be reviewed monthly by the centre manager. The centre manager will bring up and discuss one safeguarding policy at every weekly team meeting.

	<p>Centre management must review and update their Child Safeguarding Statement to include all potential risks relevant to the young people in this service. All management and staff must be familiar with their CSS.</p> <p>Centre management must provide a schedule of training to identify current gaps related to child protection and safeguarding.</p> <p>The use of shared bathrooms requires immediate review, and a robust risk assessment must be implemented to determine factors to be considered when assigning young people to these rooms. Additional safeguards must also be considered and implemented as necessary.</p>	<p>The centre manager has reviewed and updated the Child Safeguarding Statement to include all relevant risks, with specific emphasis on CSE, consultation with Social Work team and trafficking as standalone risks. This document was discussed with the staff at their team meeting on <b>11 February 2026.</b></p> <p>The centre manager has developed and implemented a training schedule to address gaps related to child protection and safeguarding This was completed on 6 February 2026.</p> <p>The Registered Proprietor conducted a site visit of the centre on 11 February 2026, in consultation with building professionals and building works were completed to ensure 5 of the young people have access to a private bathroom and 2 young people share an independent bathroom.</p>	<p>An annual review of the CSS will take place sooner if risks change. The CSS is included in staff induction and refresher training. The CSS will be discussed at the staff team meetings once a month for the next 6 months.</p> <p>A training log will be monitored monthly by the centre manager. The area manager will review training quarterly as a function of their external audits. Automatic reminders for refresher training will take place.</p> <p>Risk assessments will be completed prior to placement and reviewed regularly.</p> <p>Environmental risks reviewed as part of monthly health and safety audits.</p> <p>Collective Risk Assessment completed at admission meetings.</p>
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	<p>Centre management must implement a system for recording matters related to child protection that do not meet the threshold for reporting. All staff should be familiar with this system.</p>	<p>The policy on shared bathrooms was reviewed and updated to reflect changes to the policy on 5.2.26 (see attached)</p> <p>The centre manager has developed a formal system for recording, tracking, and reviewing child protection concerns that do not meet the reporting threshold. This was brought to staff and discussed at their team meeting on <b>11 February 2026</b>. Below threshold concerns will be recorded on the incident report template and monitored by the centre manager and area manager through the centre's risk register.</p>	<p>All child protection concerns that do not meet the threshold, and the process of recording same, will be reviewed at monthly management meetings with centre manager and area manager.</p>
5	<p>The registered proprietor must satisfy themselves that the centre manager is familiar with all aspects of the service and delivering effectively on all named responsibilities.</p>	<p>The new centre manager is the DLP. The new centre manager has been provided with their job description, and roles and responsibilities are reviewed weekly with the area manager.</p> <p>An audit tool will be developed and implemented <b>by June 2026</b>, for all centre managers in the service to measure centre compliance against best practice, including regulations and standards.</p>	<p>There will be ongoing supervision from area manager, both through the formal process, but also on an ongoing basis, to support the centre manager in their role as person in charge, and to ensure compliance with the delivery of a safe and effective service.</p> <p>The annual performance and governance review will give an overview of the centre</p>

	<p>The registered proprietor must ensure that practices for recruitment and selection comply with their own policy.</p> <p>The registered proprietor and centre management must undertake a review of the policy and accompanying procedures related to risk and ensure that the approach is robust and responsive.</p>	<p>Policies for recruitment and selection were reviewed to ensure practices comply with the centre’s policies by the registered proprietor, area manager and centre manager on <b>6 February 2026</b>.</p> <p>The registered provider and centre manager reviewed and updated the risk assessment policy and procedures, completed on 6 February 2026 and it was introduced to the team on <b>12 February 2026</b>.</p> <p>A Risk Register has been implemented in the centre. Centre manager has completed a consultation piece with an external consultant on <b>3 February 2026</b>.</p>	<p>managers work throughout the year, and plans for further development.</p> <p>The area manager will review the implementation of the audit tool, and work with the centre manager to ensure compliance in all areas.</p> <p>Responsive Workforce will be reviewed by the area manager quarterly as a function of their audits and written feedback being provided to the proprietor regarding staff recruitment needs for the centre.</p> <p>Policy on Recruitment will be reviewed annually as part of the full policy review.</p> <p>Monthly review of the risk registers will take place by the centre manager and area manager. Risk assessments will be included in supervision and handovers. Risk assessments will be reviewed weekly by the centre manager and prior to admission meetings. External consultant will arrange a consultation with the centre manager bimonthly to review the risk register.</p>
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	<p>Centre management and the registered proprietor must commit to a full review of the suite of policy documents.</p>	<p>Bimonthly consultation with centre manager and external consultant will take place. All staff in the centre to complete risk management training <b>by 1 June 2026.</b></p> <p>The centre manager, area manager and registered provider has undertaken a full review of the policy documents. This was <b>completed on 12 February 2026.</b> The full policy document was available to the staff team on 12 February 2026, and they were presented to, and discussed with the team, on <b>18 and 19 February 2026.</b> Policies and procedures will be a rolling item on team meetings going forward with a policy brought to each meeting.</p>	<p>The policies will be reviewed annually or sooner, if required. Any updates to the policies will be notified to the centre manager and staff team at team meetings and supervision sessions. Additional training will be organised if required. Adherence to policies will be reviewed as a function of the managers monthly audits. The manager will bring one policy to weekly team meetings. Policies will also be reviewed with individual staff members during supervision sessions.</p>
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