An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 244

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Spring Life Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**7th & 8th October 2024**
Registration Status:	**Registered from 7th May 2024 to the 7th May 2027**
Inspection Team:	**Anne McEvoy** **Sinéad Tierney**
Date Report Issued:	**18th December 2024**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.

The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined. During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 07th May 2024. 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 from the 07th May 2024 to the 07th May 2027.

On the 1st October 2024, following the receipt of information provided by the registered provider in advance of this scheduled inspection it was determined that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 7 Staffing and following correspondence with the registered provider, a decision was made to attach a condition of no further admissions. This condition was removed on the 13th December 2024 following receipt of updated staffing information and a review of the corrective and preventative actions submitted to the inspectorate following this inspection.

The centre was registered as a multi-occupancy service. It aimed to provide care for two young people from age thirteen to seventeen years. The Well Tree model of care was the approach adopted by the centre and it aimed to assist young people come to terms with their past and prepare for a brighter future through nurturing the growth and development of the young people in their care. There was one child living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.3
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social

workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young person, 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 06th November 2024. 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 22nd November 2024. This was not deemed to be satisfactory and the registered provider was provided with feedback and additional time to finalise the CAPA. The final CAPA was received on the 12th December 2024. 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: 244 without attached conditions from the 07th May 2024 to the 07th May 2027 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
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 wellbeing and personal development.

The young person was admitted to the centre in August 2024 and a child in care review was held within four weeks of their admission to the centre. This was in line with statutory timeframes. The centre had the previous care plan dated March 2024 on file and was awaiting the updated care plan from the child in care review held in the three weeks prior to the inspection. The allocated social worker had provided the centre with comprehensive minutes from the child in care review and this document was sufficiently detailed for the centre to plan individual work until the updated care plan was received. Inspectors found that the centre had not developed a placement plan to guide care staff in the work that needed to be undertaken with the young person. Inspectors reviewed all individual work records written and found that while some goals identified in the child in care review were being targeted there was no system to identify and track the progress of these goals. The registered provider and centre manager were instructed to develop a placement plan as a matter of urgency to ensure that goals identified in the child in care review were recorded and efforts to progress them noted.

The young person did not attend their child in care review, but they were provided with the opportunity to complete the child in care review form and have their views and opinions heard at the meeting. There was evidence that the allocated social worker met with the young person and provided feedback to them on the decisions made at the review. The young person had an appointed key worker, but the key worker also held a management function. Inspectors found that the dual tasks of being on the management team and being key worker for the young person limited the care staff's ability to perform either task to an acceptable level. Inspectors recognised that there was a good relationship between the young person and the key worker but recommend that as soon as the centre has sufficient staff, the function of key worker be assigned to a member of staff with the capacity and time to perform the role to a satisfactory level. Significant key work was identified in the child in care

review such as encouraging and prompting self-care, as well as information on sexual health and guidance in managing and controlling emotions. This key work had yet to begin.

The assessment and consultation service (ACTS) were named at the child in care review as being available to provide support and guidance to the staff team, however following a review of all documentation in the centre, inspectors could not find any reference to guidance provided to care staff. The social work team subsequently stated that ACTS were waiting for identified long term care staff to be in place and at that point they were to resume support in terms of behavior management guidance. There were health goals identified in the review involving external supports such as outstanding vaccinations. Inspectors were unable to find evidence that the young person was being supported and facilitated to access this external support in line with care planning, however the centre diary evidenced that a dental check up was arranged for the young person.

Inspectors found that the allocated social worker had visited the centre twice in the six weeks since the young person was admitted. In interview, the social worker noted that they had regular communication with the centre. However, inspectors found that the centre was not robust in its communication with the social worker regarding the implementation of restrictive practices and the resulting impact on care experienced by the young person.

Inspectors attended the handover meeting and found that the written record was inaccurate regarding the names of staff on shift and the times they were working and there was no evidence of care planning for the day ahead either within the written record or in the verbal handover. In reviewing the centre records and the young person's care file, inspectors found that the records were difficult to navigate. There was a lack of clarity regarding daily planning for the young person in minutes of team meetings or handover records. The young person's care record was limited and not all information regarding care planning was stored on the care record. Inspectors were advised of additional information, relevant to care planning, in a centre diary that was not recorded on the young person's individual file. In addition, the centre did not hold a centre register of young people residing in the centre. The registered provider was advised that they must ensure that a centre register is held and updated in line with the Child Care (Placement of Children in Residential Care) Regulations, 1995. Inspectors also observed that some centre records were stored in an unsecure cabinet. The centre management must ensure that the privacy of personal information is protected and respected.

Inspectors recognise that the centre was operating with exceptionally low levels of qualified, experienced staff in the centre (which will be discussed under standard 6.1). This point, alongside the fact that the young person was only in the initial stages of their placement, had yet to develop any significant relationships with care staff, the absence of a placement plan to guide care staff and the absence of an accepted behaviour management framework contributed to a crisis driven response by care staff on shift.

Compliance with Regulation	
Regulation met	**None identified**
Regulation not met	**Regulation 5** **Regulation 17**

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

Actions required

- The registered provider and centre management must ensure that a centre register is developed in line with the Child Care (Placement of Children in Residential Care) Regulations, 1995.
- The registered provider and centre management must ensure that information relating to the young people residing in the centre is recorded in a way that promotes appropriate sharing of information with care staff and good care planning for any young people resident in the centre.
- The registered provider must ensure that centre records containing personal information are treated as confidential and protected.
- The registered provider and centre management must ensure that the centre develop a placement plan for young people in their care outlining the child's needs and supports required, as identified in the care planning process. This process must be captured in centre policy, identifying timeframes for the completion and updating of placement plans.

- The registered provider and centre management must ensure that young people in the centre are provided with opportunities to be involved in the placement planning process and provide input into their placement plan.
- The registered provider and centre management must ensure that there is effective communication by centre staff to the allocated social worker notifying them of information relevant to the care experienced by the young person to ensure continuity of care and adherence to the child's care plan.

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

Inspectors found that the centre did not provide an open culture where care staff and young people were encouraged to raise concerns and report incidents. A review of centre records did not evidence any opportunities for care staff to note areas for improvement. There were no supervision records to review and no schedule of supervision identifying when supervision was to begin. Team meeting records were limited in their recording and did not evidence any areas of care practice or areas for improvement discussed by staff.

In policies and procedures provided to the inspectorate, the registered provider stated that the centre had an identified complaints and compliance quality assurance officer. The registered provider clarified that this role is for the management of complaints by staff. There was no complaints officer to receive, review or assess complaints made by any young person residing in the centre. The registered provider also confirmed during the inspection that the above-named compliance officer also did not have any role in reviewing centre records and providing oversight or identifying areas for improvement.

The centre had a policy on managing complaints by young people. A full review of this policy identified that large portions of the policy were taken from the Tusla Child and Family Agency policy on dealing with and managing complaints and was not relevant or applicable to the residential centre. Aspects that were relevant detailed; that should the young person have a grievance they would be provided with a complaint form. When inspectors requested a copy of this complaint form, they were

provided with a copy of the child protection and welfare report form (CPWRF). On further enquiry, they were provided with a copy of the Tusla Tell Us complaint form and following additional clarification a blank complaint form was provided to the inspectors. Inspectors were informed that the young person had not made any complaints since their admission to the centre however, during the inspection, inspectors observed a number of occasions when the young person displayed dissatisfaction with the care they were receiving. These incidents were not considered by care staff or management as opportunities for receiving feedback or identifying areas for improvement.

The centre policies stated that each young person was to be provided with a "young persons booklet" on admission. This booklet was to inform the young person on opportunities for them to give feedback, air grievances and make complaints. When inspectors requested this booklet, the registered provider and staff were unable to locate it and there was no evidence that this booklet had been shared with the young person on their admission.

Inspectors visited the centre on two consecutive days and observed concerning care practice in the management of incidents. On one occasion, care staff and management isolated themselves from the young person when the young person was triggered and engaged a restrictive practice of locking internal doors and limiting the young person's mobility. Inspectors observed the young person to be isolated in the hallway requesting access to care staff with no response from staff on shift. This further escalated the situation and resulted in the young person removing the door handle from the office door with a screwdriver. The registered provider had requested assistance from An Garda Síochána. One inspector remained present with the young person in the hallway, until an oncoming member of staff entered the premises and engaged the young person. Inspectors found both through a review of significant events and through observation on inspection, that there was an over-reliance on requesting the presence of An Garda Síochána and a lack of understanding regarding the individual crisis support plan in place for the young person. The registered provider confirmed that there was no recognised behaviour management framework in place in the centre and the individual crisis support plan did not provide clarity on how to support the young person through a developing incident.

Inspectors found that restrictive practices were implemented in the centre as a behaviour management technique. There was no register identifying the restrictive practices in place and while the allocated social worker was aware of some of them,

there were others that the social work team had not been informed about. There were no risk assessments undertaken on the restrictive practices in place and no evidence that they were reviewed to determine their ongoing necessity. The social work department were confident in their communication with the inspectors that the young person was aware of the complaints policy and knew how to make a complaint. However, there was no evidence that the young person had been advised of their right to make a complaint or discuss how these restrictive practices could be reduced or eliminated in line with the National Standards for Children's Residential Centres HIQA (2018).

Policies provided to inspectors documented that the centre had a "reportable events" procedure and register. The policy further stated that a Reportable Event Regional Review Group (RERRG) had a role in reviewing reportable or significant events. The policy did not identify the timeframes for the reporting of significant events, nor did it identify which staff members were to participate in a RERRG. Inspectors were not provided with the reportable events procedure and there was no written procedure available for care staff. None of the significant event notification forms completed since the admission of the young person were subject to a review and team meeting minutes did not evidence discussion regarding significant events or any potential learning that may have arisen. Inspectors were advised that no care staff had received supervision since the centre had opened so there were no opportunities for care staff to discuss or analyse the significant events for any potential trigger or learning.

Inspectors reviewed all significant event notification (SEN) forms since the young person was admitted to the centre. Numerous errors were noted on the initial SEN forms- the young person's age was incorrect, the name of the guardian ad litem appointed to the young person was incorrect, there were irrelevant professionals such as clinical co-ordinator and senior psychologist noted as professionals to be notified, and the allocated social worker to be informed was not named on the initial notifications. There was no written oversight by the person in charge and no evidence of any review of the information or guidance provided to care staff.

While a review of centre communication did not evidence that all significant events were notified to the social worker, in interview, the allocated social worker stated that they had received notification of all significant events since the young person was admitted and that these notifications were received in a timely manner. Errors on the notification form relating to the professionals to be notified were discovered by the allocated social worker and feedback provided to the centre management. The

notification form was subsequently amended to include the correct names of those professionals to be notified.

Compliance with Regulation	
Regulation met	**Regulation 16**
Regulation not met	**Regulation 5**

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

Actions required

- The registered provider must ensure that all policies and procedures are relevant to the purpose and function of the centre.
- The registered provider and centre management must ensure that there are suitable opportunities for care staff and young people to raise concerns and identify areas for improvement.
- The registered provider and centre management must ensure that the policy on the reporting, recording and reviewing of incidents is assessed and enhanced to identify timeframes for reporting of incidents, participation in RERRG and how learning will be used to inform best practice.
- The registered provider must ensure that a behaviour management framework is adopted in the centre and that all staff are trained to implement it.
- The registered provider and centre management must ensure that all restrictive practices are recorded on a restrictive practice register, that they are discussed with the allocated social worker, that risk assessments are completed and that all restrictive practices are reviewed on an ongoing basis to determine their ongoing need.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

At the time of this inspection, the centre was experiencing significant staffing issues. As noted earlier in this report, on the 1st October 2024, following the receipt of information provided by the registered provider, it was determined that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 7 Staffing and the centre was issued with correspondence proposing to attach a condition of no further admissions.

At the time of registration, in May 2024, the registered provider had identified sufficient numbers of staff to work in the centre, however through the course of the inspection it emerged that some of these staff members were not available to commence employment and were still in the process of resigning from their current positions. Additionally other staff members identified to work in the centre were still in the process of achieving compliance with the Central Compliance Unit (CCU).

The registered provider was acting as the person in charge and centre manager. The centre had one deputy manager, one social care worker and two health care assistants. The centre also had access to one relief social care worker. The remainder of the shifts were completed by agency staff. The registered provider notified the inspectorate that the appointed social centre manager and second deputy social care manager were available to begin working in the centre from December 2024. The registered provider also provided a full staffing list of those staff who were awaiting compliance approval from the CCU. The centre had an additional seven social care workers awaiting compliance and one health care assistant awaiting compliance.

Inspectors reviewed rosters for the centre and found that in the week prior to the inspection, three members of staff had completed 36 consecutive hours of work. They had each completed a day shift, a waking night shift, followed by another day shift. Additionally, the person in charge had completed 136 work hours in the centre in the week prior to the inspection. This presented a safeguarding issue, was unsafe practice and in contradiction to the Organisation of Working Time Act 1997. The registered

provider was instructed to ensure that care staff were rostered off for appropriate and necessary rest times, in line with legislation.

Throughout the course of the inspection, inspectors found it challenging to ascertain correct and accurate information relating to staffing. Inspectors were persistently provided with conflicting information relating to the start and finish times of care staff and the overall working hours completed by staff. In addition, after the visit to the centre, inspectors became aware that one staff member who was notified to the inspectorate as being a full-time member of staff, was also employed full time by another company. This information was not made known to the inspectors during interview or during the visit to the centre. Subsequently, the care staff is now working solely for Spring Life Ltd.

A review of handover records and staff sign in sheets demonstrated discrepancies in the recording of staff on duty. It was evident that records were pre-populated with information regarding the names of staff expected to come on duty and the times they were expected to arrive and leave at. The registered provider was advised that this practice must cease and accurate records of staff on duty and the times they started and finished shift were to be maintained.

The registered provider stated that while they were awaiting compliance approval for care staff from the CCU, they had secured agreement with an agency for the provision of agency staff to the centre. There was an agreement that the agency was to provide the same staff on an ongoing basis to the centre to cover shifts to maintain consistency for the young person. The registered provider stated that a core member of staff for the centre was always on shift to support agency staff.

Inspectors reviewed training undertaken by care staff in the centre and found that while Tusla's Children First e-learning programme: Introduction to Children First had been undertaken by core members of staff, in discussions with care staff and the registered provider, there was no awareness of the role of designated liaison person (DLP) or consensus on who performed that task in the centre. The child safeguarding statement (CSS) did not name the DLP and references the person-in-charge as the "mandated person" for the centre. Further confusion around safeguarding protocols was evidenced when inspectors requested a complaints form and instead were provided with a child protection and welfare report form. The registered provider must ensure that the CSS is updated to identify the DLP in the centre and that all staff, including management, are aware of their roles and responsibilities regarding

child safeguarding and are confident in reporting child protection and welfare concerns through the Tusla portal.

Inspectors found that there were procedures in place for on-call arrangements for evenings and weekends. However, a review of this roster evidenced that one of those rostered to provide on-call support was not qualified or experienced in social care. There was no written record of when on-call was utilised or the guidance offered from the rostered on-call staff.

Inspectors acknowledged that there was evidence that the registered provider was undertaking workforce planning.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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

Actions required

- The registered provider must notify Alternative Care Inspection and Monitoring Service when they have a full staffing complement and achieve compliance with the Tusla ACIMS staffing regulatory notice, Minimum Staffing Level and Qualifications for Registration of Children's Residential Centres, dated August 2024.
- The registered provider must ensure that the working hours of care staff is in compliance with the Organisation of Working Time Act 1997.
- The registered provider must ensure that accurate records of staff on duty and the times they start and finish shift are maintained.
- The registered provider must ensure that the child safeguarding statement is updated to identify the name of the designated liaison person in the centre and that all staff are trained to understand their roles and responsibilities for child safeguarding.

- The registered provider must ensure that the on-call duty is undertaken by qualified and experienced members of staff and that a record of guidance given is maintained in the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered provider and centre management must ensure that a centre register is developed in line with the Child Care (Placement of Children in Residential Care) Regulations, 1995.	A centre register was developed in compliance with the Child Care (Placement of Children in Residential Care) Regulations, 1995. On the 27 November 2024 processes were implemented to ensure the accuracy of the register, with periodic internal reviews.	The centre manager will update the centre register immediately upon the admission or discharge of any young person to ensure compliance with the Child Care (Placement of Children in Residential Care) Regulations, 1995. Register will be reviewed annually and updated as necessary.
	The registered provider and centre management must ensure that information relating to the young people residing in the centre is recorded in a way that promotes appropriate sharing of information with care staff and good care planning for any young people resident in the centre.	The recording of information was standardized on the 5th, November 2024 to ensure appropriate sharing among care staff and alignment with care planning requirements. Information was disseminated effectively through structured handovers and team meetings.	Standardized templates for recording information about young people will be maintained and regularly reviewed by the centre manager to ensure they promote effective communication and care planning. Weekly team meetings and daily handovers will continue to be used to share relevant information regarding young people's care.

		Regular reviews during team meetings were introduced to ensure the shared information supports good care planning.	Annual training sessions will be conducted to reinforce staff understanding of effective recording and sharing practices.
	The registered provider must ensure that centre records containing personal information are treated as confidential and protected.	Physical records containing personal information were secured in lockable filing cabinets with restricted access. Policies were updated on the 2nd of December 24 to reinforce the confidentiality requirements, and centre managers were tasked with overseeing compliance. Confidentiality procedures were evaluated to address any risks.	Personal records will continue to be securely stored in lockable cabinets with restricted access to authorized personnel only. The confidentiality policy will be reviewed annually to ensure it remains comprehensive and aligned with current best practices. Monthly checks will be carried out by the centre manager to ensure adherence to confidentiality policies and to address any breaches immediately.
	The registered provider and centre management must ensure that the centre develop a placement plan for young people in their care outlining the child's needs and supports required, as identified in the care planning process. This process must be captured in centre policy, identifying timeframes for the	A placement plan was created by the centre manager for the young person in the centre, reflecting needs and supports outlined in the care planning process on the 9th of November 2024. The process was formalized into centre policy, specifying a three-month timeframe for updates with next review date of 25 January 2025. Placement plans were	The centre manager will oversee the development of the4 placement plan for each young person within two weeks of their admission, reflecting their needs and supports. Reviews and updates to placement plans will occur in supervision with the key worker every three months or earlier if the young person's circumstances change. Policies detailing the placement

	completion and updating of placement plans.	integrated into team meeting discussions to ensure alignment with evolving needs.	planning process will be reviewed annually to ensure they continue to meet regulatory requirements.
	The registered provider and centre management must ensure that young people in the centre are provided with opportunities to be involved in the placement planning process and provide input into their placement plan.	Opportunities were provided for young people to review and provide feedback on their placement plans during scheduled key worker session on the 27 November 2024. Feedback key work sessions will be conducted monthly by the allocated key worker, allowing young people the opportunity to contribute meaningfully to the planning process. Placement planning meetings incorporated their feedback to ensure active participation and ownership of their care plan.	Young people will be given regular opportunities to provide input to their placement plans during key worker sessions. Feedback mechanisms will ensure that young people's perspectives are consistently captured and integrated into their plans. Quarterly reviews by the centre manager will ensure that young people's involvement in the planning process is meaningful and effective.
	The registered provider and centre management must ensure that there is effective communication by centre staff to the allocated social worker notifying them of information relevant to the care experienced by the young person to	A communication protocol was established to notify social workers within 24 hours of significant developments in a young person's care on the 15th of October 2024. Weekly updates to social workers were implemented, with additional updates as required for urgent matters.	A communication protocol will be maintained to notify social workers of any significant developments within 24 hours and provide weekly updates on progress. A designated staff member will monitor and log all communications with social workers to ensure accuracy and

	ensure continuity of care and adherence to the child's care plan.	A designated communication log was maintained to ensure transparency and adherence to the protocol.	accountability. Biannual evaluations of the communication process will be conducted by the centre manager to identify any potential areas for improvement and ensure alignment with care plans.
3	The registered provider must ensure that all policies and procedures are relevant to the purpose and function of the centre.	All policies and procedures were reviewed and updated 15th of October 2024 to ensure alignment with the centre's purpose, function, and care model. A comprehensive audit of policies was conducted, and updates were approved by management 25th October 2024 to ensure their specificity to the Welltree Model of Care. Ongoing review processes were established to ensure that policies remain relevant and reflective of the centre's objectives.	A biannual review schedule for all policies and procedures has been implemented to ensure they remain relevant to the centre's purpose and the Welltree Model of Care. A designated policy oversight team will monitor changes in regulations and best practices, incorporating necessary updates promptly. Staff training sessions will include briefings on policy changes to ensure full understanding and compliance. All staff are required to sign after reading.
	The registered provider and centre management must ensure that there are suitable opportunities for care staff and young people to raise concerns and identify areas for improvement.	Regular staff and young people's feedback sessions were introduced to provide suitable opportunities for concerns to be raised. A suggestion box was implemented to allow anonymous submission of	Quarterly feedback sessions for staff and young people will be organized to discuss concerns and identify areas for improvement. The anonymous suggestion box will be monitored monthly, and

		concerns and improvement ideas on the 25th of November 2024. In addition, supervision templates will be amended by the end of the year to allow for staff to discuss any areas of concern or improvement. Feedback from these sessions are now discussed in monthly team meetings and documented in action plans for follow-up.	submissions will be reviewed in management meetings for action planning. A dedicated staff liaison officer has been appointed to oversee the resolution of concerns raised and communicate outcomes effectively.
	The registered provider and centre management must ensure that the policy on the reporting, recording and reviewing of incidents is assessed and enhanced to identify timeframes for reporting of incidents, participation in RERRG and how learning will be used to inform best practice.	On the 5th of November 2024 the incident reporting policy was revised to specify timeframes for reporting minor incidents within 24 hours and major incident within 1 hour. Quarterly reviews of all incidents to identify patterns and areas for improvement were implemented. Root Cause Analysis: For significant incidents have been established to understand underlying issues. Participation in the Risk Escalation and Response Review Group (RERRG) was formalized, with regular attendance and updates being incorporated into the policy.	Clear timeframes for incident reporting and review will be reinforced through staff training and included in the centre's operational manual. Participation in the Risk Escalation and Response Review Group (RERRG) will be reviewed quarterly by the centre manager to ensure adherence and to evaluate the effectiveness of learning mechanisms. Incident review findings will be integrated into annual staff development plans to promote continuous learning and improvement.

		In addition, learning review mechanism was introduced to ensure that incident analysis informs best practices and staff training.	
	The registered provider must ensure that a behaviour management framework is adopted in the centre and that all staff are trained to implement it.	A behaviour management framework, aligned with the WellTree Wellbeing Outcomes Framework, was adopted and integrated into the centre's policies. On the 10th of November 2024 all staff completed a training session on implementing the behaviour management framework effectively. Annual refresher training is scheduled to maintain staff competency and understanding.	Ongoing staff training on the behaviour management framework will be conducted annually, with additional support offered as needed. The framework will be reviewed and updated annually by the centre management to ensure alignment with emerging best practices and regulatory changes.Behaviour management practices will be discussed in monthly team meetings to ensure consistent application across all staff members.
	The registered provider and centre management must ensure that all restrictive practices are recorded on a restrictive practice register, that they are discussed with the allocated social worker, that risk assessments are	A restrictive practice register was established, on the 12th of September 2024 to ensure all practices are documented comprehensively. Protocols were introduced for discussing restrictive practices with the allocated social worker, completing risk assessments, and	The restrictive practice register will be reviewed monthly to ensure all practices are documented and assessed for necessity. A system for mandatory consultation with social workers on restrictive practices has been formalized.

	completed and that all restrictive practices are reviewed on an ongoing basis to determine their ongoing need.	reviewing the need for practices regularly. A monthly review meeting is now held to evaluate the necessity and appropriateness of all restrictive practices, ensuring their alignment with best practices and regulations.	Risk assessments and reviews of restrictive practices will be conducted quarterly to evaluate their appropriateness and impact on young people. A designated oversight officer will ensure adherence to best practices and regulatory standards related to restrictive practices.
6	The registered provider must notify Alternative Care Inspection and Monitoring Service when they have a full staffing complement and achieve compliance with the Tusla ACIMS staffing regulatory notice, Minimum Staffing Level and Qualifications for Registration of Children's Residential Centres, dated August 2024. The registered provider must ensure that the working hours of care staff is in compliance with the Organisation of Working Time Act 1997.	The registered provider has notified the Alternative Care Inspection and Monitoring Service (ACIMS) of achieving a full staffing on the 18th of November 2024 in compliance with the Tusla ACIMS staffing regulatory notice dated August 2024. Compliance was achieved by ensuring all roles are filled with qualified staff as per regulatory requirements. All remaining staff must ensure compliance by January 10th, 2025. Staff schedules were revised on the 9th of October 2024 to ensure full compliance with the Organisation of Working Time Act 1997. Ongoing monitoring has been established to ensure staff do not exceed	The Alternative Care Inspection and Monitoring Service (ACIMS) will be notified if the centre has any changes to staffing compliance. Regular internal reviews of staffing levels will be conducted to ensure ongoing adherence to the Tusla ACIMS staffing regulatory notice. Staff rosters will be reviewed weekly by the centre manager to ensure compliance with the Organisation of Working Time Act 1997. A monitoring system will remain in place to flag any deviations from the permissible working hours.

		legal working hours, and records are reviewed monthly by management.	
	The registered provider must ensure that accurate records of staff on duty and the times they start and finish shift are maintained.	A system for recording staff attendance, including start and finish times, was implemented using a centralized log on the 9th of October 2024. Daily oversight by the centre manager ensures that all staff sign in and out accurately. All staff were required to read and sign the clear guidelines on attendance documentation.	A robust log system will be maintained to record the start and finish times of all staff on duty, with oversight by the centre manager. Arbitrary monthly audits will be conducted to ensure the accuracy of attendance records. Clear guidelines on attendance documentation will be distributed and reinforced during staff induction and refresher training.
	The registered provider must ensure that the child safeguarding statement is updated to identify the name of the designated liaison person in the centre and that all staff are trained to understand their roles and responsibilities for child safeguarding.	The child safeguarding statement was updated on the 13th November 2024 to include the name of the designated liaison person (DLP) in the centre. All staff have completed child safeguarding training in November 2024 ensuring they understand their roles and responsibilities.	The child safeguarding statement will be reviewed and updated annually to ensure the designated liaison person (DLP) details remain current. Staff will receive child safeguarding training as part of their induction, with refresher sessions conducted annually. Audits of safeguarding procedures will be carried out biannually by the centre manager to verify staff understanding and compliance.

	The registered provider must ensure that the on-call duty is undertaken by qualified and experienced members of staff and that a record of guidance given is maintained in the centre.	Only qualified and experienced staff are now assigned on-call duties, and their qualifications are verified before assignment. A structured log for recording guidance provided during on-call duties was implemented on 25th November 2024 and is reviewed monthly to ensure completeness and accuracy.	A qualification verification process will be implemented for all staff assigned to on-call duties. formal training program will be established for staff to prepare them for on-call responsibilities. Logs of on-call guidance will be reviewed monthly by the centre manager to ensure completeness and adherence to best practices.