An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 268

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Laragh Family Support**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**7th, 8th & 9th January 2026**
Registration Status:	**29th November 2024 to the 29th of November 2027**
Inspection Team:	**Catherine Hanly** **Cora Kelly**
Date Report Issued:	**23rd April 2026**

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 as a single occupancy service on the 29th of November 2024. At the time of this inspection the centre was in its first registration and was in year two of the cycle. Following that centre's first inspection in March 2025, the registered proprietor applied for, and was granted, approval to transfer that registration of this centre to a new property and to increase the registered capacity to two young people.

The centre was registered to provide short to long-term emergency residential placements in a social care led environment. This service described itself as being child friendly and child led through weekly planners. Its statement of purpose described the service as thriving on providing young people with consistency, boundaries, structure and a holistic environment. There were two young people living in the centre at the time of the inspection.

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	5.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including the service director, the acting centre manager and staff members, and the allocated social workers for both young people. Inspectors met with one of the young people to discuss their experience of and views on the centre and the second young person declined the opportunity to meet with inspectors. Both young people completed questionnaires for inspectors. 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 3rd of February 2026. 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 16th of February 2026. This was deemed to be not satisfactory, and the inspection service wrote to the registered proprietor and acting centre manager advising them of same and requesting that a more robust and detailed CAPA be submitted. A second CAPA was submitted on the 26th of February with supporting documentation. This CAPA was accepted by the Alternative Care Inspection and Monitoring Service (ACIMS) though noting that further development of policies remains necessary.

This centre has remained under review with the National Registration Enforcement Panel NREP since their first inspection in March 2025. Accordingly, the findings of this inspection were presented to NREP, and it was agreed that a review of the implementation of the CAPA submitted in response to the findings of this inspection in January would be undertaken by the end of April 2026.

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: 268 without attached conditions from the 29th of November 2024 to the 29th of November 2027 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 registered provider had further developed policies in safeguarding and child protection since the inspection of the centre in March 2025. Training in these policies was directed by inspectors and committed to by centre management in the corrective and preventative action plan (CAPA) included in the final inspection report. Inspectors found that no formal plan had been implemented in the intervening nine months since that inspection, representing a failure to comply with their own commitment to respond to deficits identified. On this inspection, staff and the centre management interviewed did not present with a sound knowledge of their responsibilities or guiding policies in relation to child protection. They were not aware of the risks named in the centre's child safeguarding statement (CSS), nor were they familiar with the presenting vulnerabilities and some of the risks that the young people in placement presented with. Inspectors found that risk assessments were insufficiently detailed – some did not name the actual risk presenting, rather they described a young person's history connected to the presumed risk; they did not take full account of the extent of the presenting risk; they lacked evidence of consultation with social workers; and the impact of the presenting risk on the other resident; they also lacked the identification of solid interventions. Inspectors found that there were no statutory care plans on file for either young person in placement, although both social workers confirmed that child in care reviews (CICR) had occurred. Inspectors directed both social workers to provide the centre with a copy of the updated statutory care plan. Additionally, there were no placement plans, devised by the manager and staff team, to guide either young person's placement in this centre. There were no recorded key working sessions with either young person on matters including sexual health, sexual identity, contraception, keeping oneself safe, and appropriate peer relationships and expectations of same, for example.

The Child Safeguarding Statement (CSS) was not in compliance with the Children First Act, 2015, and Tusla requirements. Social media risks and risks relating to child sexual exploitation were not included in this. Sentences within he document itself

were incomplete. The registered provider must undertake an immediate review of the CSS for the centre, ensure it is inclusive of all relevant information.

The acting manager was identified as the designated liaison person (DLP) and named as such in the policy document. They reported to inspectors that they had completed relevant training in this, however inspectors were unable to verify this as it was not on the records of training provided for review. There was no named deputy DLP in the centre policy although inspectors were informed that one of the social care leaders held this role and had completed training in same. There was no written evidence of this submitted to inspectors. The centre policy document stated that all employees of the service were mandated persons and inspectors were informed that all members of the staff had completed mandated persons training. The policy document read as contradictory, however, as it specified that mandated persons were those with specific training and qualifications which not all the current staff team had. Staff in interview did not demonstrate a familiarity with the role and responsibilities of a mandated person with one stating they were not a mandated person but couldn't explain why. There was no evidence of the records of mandated persons training completed provided to inspectors. The policy document lacked guidance to staff on making a report of a retrospective disclosure of abuse. It did not include relevant detail on how or where to record concerns that did not meet the threshold of reporting as a child protection concern. The policy title relating to protected disclosures was incorrectly spelled. The registered provider must review their policies on safeguarding and child protection to ensure they are clear and compliant with Children First: National Guidance for the Protection and Welfare of Children (2017) and seek expert input if necessary. They should be clearly and correctly titled, and the document itself should be numbered correctly.

Staff and management did not provide sufficient evidence that they clearly understood what constituted a child protection and welfare matter of concern and their reporting responsibilities in relation to same. Inspectors found that child protection and welfare report matters were recorded and reported as an incident. There was unnecessary duplication in incident reports reviewed and this should cease. There was no verifiable evidence that incidents had been or were being reviewed despite several recorded incidents for both young people – some of a high-risk nature. Inspectors found a record relating to a young person being offered and accepting the opportunity to make a complaint relating to a practice at the centre but could not find where or if this had been formalised by them and responded to by centre management. This was not in line with the centre's own policy on complaints. The registered provider must create a robust policy and practice on significant events.

This should include clear guidance for staff on recording and reporting such matters promptly. The policy and practice must also include a system of regular review with actions clearly named where required and ensure this is followed through on.

There was no accompanying child protection and welfare report form (CPWRF) or indeed evidence that matters recorded as child protection had been reported as such through the Tusla portal in line with legislation. Inspectors found that one recorded incident referenced within the detail a Tusla portal number. The centre did not maintain a register for CPWRFs. Whilst this is not a mandatory requirement, it would assist in oversight and tracking of the status of child protection concerns made through the portal. The acting centre manager and registered provider were unable to provide information to inspectors on the status of the child protection concerns reported as incidents by the previous acting centre manager. They did seek this information off the allocated social work team but, at the time of writing this inspection report, they had not received an update. The inspector followed up with one young person about whom reference had been made to child protection reports in their file at the centre. The social work team did not respond to this request for information. Inspectors reviewed two separate records of episodes of missing child from care (MCFC) for one young person that, given known risks, should have also been separately reported as a CPWRF and were not.

Inspectors found that the service provider did not adequately demonstrate compliance with the standard in relation to safeguarding and child protection examined during this inspection. In addition, they found that Regulation 5, Care Practices and Operational Policies, of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 was not met.

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 3.1**

Actions required

- The registered provider must undertake an immediate review of the CSS for the centre, ensure it is inclusive of all relevant information.
- The registered provider must review their policies on safeguarding and child protection without delay to ensure they are clear and compliant with Children First: National Guidance for the Protection and Welfare of Children (2017).
- The registered provider must secure training in safeguarding and child protection, in line with the centres' revised document when compliant, for themselves, the acting centre manager and staff team.
- The registered provider must take immediate corrective action as well as ensuring on an ongoing basis that staff are aware of, and acting on their reporting responsibilities in relation to child protection matters, including that mandated persons are acting in compliance with the Children First Act.
- The acting centre manager must conduct a full review of all incidents for both young people to assure themselves that child protection concerns have been reported and to take retrospective reporting action if necessary.
- The acting centre manager must work collaboratively with the allocated social workers to identify individual needs to implement the necessary robust safeguards as a matter of priority.
- The registered provider must implement a robust system of oversight to satisfy themselves of the suitability of all care practices and operational policies.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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

In addition to an examination of standards 3.1 and 5.4, this inspection process reviewed the implementation of the centres corrective and preventative action plan (CAPA) which had been submitted in response to the findings of the first inspection of the service. Whilst inspectors acknowledge that the registration of this service transferred from an initial single occupancy to a dual occupancy service, the expectations of the requirements of either/both types of service had been clearly outlined to the registered provider in a meeting with the Alternative Care Inspection

and Monitoring Service (ACIMS) on the 4th of April 2025, following the inspection of the first registered service.

Inspectors found during this inspection, that deficits that had been identified in the inspection of the service in March 2025 and subsequently detailed in the accompanying inspection report had not been rectified at the time of this inspection. This included inadequate records relating to young people being maintained at the centre. Inspectors found that recording at the centre was not reflective of the guiding policy. This related to all forms of recording for young people including contact with social workers. Records with all external professionals must be established and clearly maintained – this must include the recording of full names, roles/title, purpose of their contact/interaction with young people and any action arising from same.

Placement plans were absent from care files at the centre and, despite the centres statement of purpose naming placement review meetings being convened on a twelve-weekly basis, this was not occurring in practice. Inspectors found that the acting manager and staff interviewed did not know the care status of young people, whether they had a statutory care plan on file, if a child in care review (CICR) had been convened, or the purpose of their placement in this centre. One young person had attended school on one occasion since their admission to this centre and had declined to return since, they were approaching their sixteenth birthday. The second young person had completed education modules online via iScoil, they had been in placement one full year at the time of this inspection and were approaching their seventeenth birthday. The manager and staff interviewed did not know what either of their prior education history consisted of or to what level they had an education. Except for one young person having completed a first aid responder (FAR) and fire training course, there was no evidence that robust efforts had been made to engage either young person in meaningful, consistent, or certified education opportunities. There was no evidence that either the acting centre manager or registered provider, as director of service, had oversight of this in terms of fulfilling their governance responsibilities. The inspection report of 2025 identified that "*The director of service and acting centre manager must ensure that there is suitable training and support provided in the expected practices and recording in placement planning and the role and tasks of the key worker.*" Inspectors found that no such training had taken place in the intervening months.

Significant deficits had been identified in the organisations' policies and procedures, with many areas of practice not having any guiding policy. At the time of the

inspection in March 2025 and in subsequent meetings the registered provider had been given guidance and feedback on the areas of policy that required development. That inspection report had also directed that training in the organisation's policies and procedures (including those relating to child protection referenced in standard 3.1 of this report) must be delivered. Management had committed to implementing such training in their written response to that inspection report. Inspectors found that policies remained undeveloped for some of the key practice areas including placement planning and key working. The policy document itself was poorly structured with misaligned page numbers from the contents page. Inspectors found that other areas of practice, such as use of petty cash monies and implementing routines for young people, lacked formal guidance and these were areas that the staff team lacked knowledge on. Although workbooks had been developed to support staff learning of relevant policies, these had either not been implemented or had not been proven to be effective as staff did not demonstrate having a sound knowledge of these in interview. The registered provider did not demonstrate a plan of action for the implementation of these workbooks or the measurement of the effectiveness of same.

Inspectors noted that aspects of the house required attention – it was cold on inspectors visit and a staff member reported that they experienced it as being cold. The laundry room was part of a converted garage that had not been insulated and was extremely cold on the day of inspectors' visit. The registered provider confirmed to inspectors that they had previously spoken with the landlord who had reportedly come to bleed radiators. However, there was no such record of this having occurred and the registered provider and manager informed inspectors that no formal system of reporting, recording and responding to matters related to property maintenance and oversight had been implemented. Inspectors directed that the registered provider seek a review of the heating system by a qualified professional and to assess options for insulation of the laundry room for consideration. Inspectors observed that there was no designated fire assembly point outside the property although fire drills recorded noted that staff and young people had assembled at the fire assembly point in drills that were reported to have been conducted. These fire drills were recorded as taking between twelve and fifteen minutes. There was no explanation given for the length of time taken to evacuate the building and the full names of person's participating were not recorded. There was no evidence on these records of oversight by the acting centre manager or registered provider. The waste bins were impeding the fire escape route from the rear of the property. A permanent alternative location for the bins must be implemented, and the registered provider must put up a fire assembly point immediately. All staff and young people must be informed of this assembly point, and it should be utilised in fire drills. If there are challenges in

evacuating the building, then the reasons for those must be documented and corrective action must be taken to address this and reduce the time taken to evacuate. The registered provider must implement a formal system of property oversight and maintenance with immediate effect.

Inspectors found that some staff continued to work double shifts. This practice had been occurring in the previous centre and was directed to cease at the time of the inspection in March 2025, except in exceptional circumstances and with a risk assessment in place. The registered provider must ensure that this direction is adhered to immediately. Team meetings were taking place monthly, via a remote forum. Inspectors were informed that this was to move to fortnightly although there was no evidence of a formal plan around this.

Given the extent of development and learning that was required, inspectors recommend that weekly team meetings are implemented for a period and that at least half of these are conducted in person. Meetings should have a clear agenda and structure inclusive of practices and policy development, structured work and engagement with young people towards the realisation of identified placement goals. Risk and the management of same should be a standing item, as well as progress review of young people within this placement.

Inspectors found that the registered provider had not implemented systems to assess the safety and quality of the care being provided in the centre against the *National Standards for Children's Residential Centres (HIQA, 2018)*. Nor was there evidence of a plan to implement such systems. The registered provider had not undertaken an annual review of compliance with the centre's objectives as is required under standard 5.4. There was no evidence that the registered provider or acting centre manager had tracked their own CAPA actions and the implementation or otherwise of same. Inspectors found that the service provider did not adequately demonstrate compliance with the standards examined during this inspection. In addition, they found that Regulation 5, Care Practices and Operational Policies, of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 was not met.

Compliance with Regulation	
Regulation met	**Regulation 6**
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 5.4**

Actions required

- The registered provider must develop and implement the necessary systems to assess the safety and quality of the care being provided in the centre against the *National Standards for Children's Residential Centres*.
- The registered provider must devise and implement a mechanism for undertaking an annual review of compliance with the centre's objectives as is required under standard 5.4 of these standards.
- The registered provider and acting centre manager must implement clear and consistent systems and methods of recording in this centre that are in line with centre policy.
- The registered provider must create a robust policy and practice on significant events. This should include clear guidance for staff on recording and reporting such matters promptly, as well as review and oversight by management.
- The acting centre manager and staff team should be familiar with all relevant aspects of each young person's placement in this centre. Their individual needs should be identified in placement plans that should be regularly reviewed and linked to all other care planning documents.
- The registered provider must commence a review of the centre policy document and outline a clear plan of completion and implementation, including the provision of training to the manager and staff team.
- The registered provider must implement a formal system of property oversight and maintenance with immediate effect. Actions detailed in this report relating to property and fire safety must be addressed as a matter of priority.
- The registered provider must oversee that the practice of staff working double shifts ceases with immediate effect unless in exceptional circumstances and where an accompanying risk assessment has been developed to inform same.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must undertake an immediate review of the CSS for the centre; ensure it is inclusive of all relevant information.	Revised CCS submitted which included added risks and DLP and DDLP information. Emailed to CCU for compliance review.	Amend based on response from CCU until fully compliant.
	The registered provider must review their policies on safeguarding and child protection without delay to ensure they are clear and compliant with Children First: National Guidance for the Protection and Welfare of Children (2017).	Revised policies on safeguarding and child protection submitted - compliant with Children First: National Guidance for the Protection and Welfare of Children (2017).	Reviewed by Director of Services and manager every six months or if incident arises.
	The registered provider must secure training in safeguarding and child protection, in line with the centres' revised document when compliant, for themselves, the acting centre manager and staff team.	All staff will complete HSE 'Let's Talk About Suicide' (E-Learning) on or before 01.03.26. All staff to complete 'Online Safety and Awareness in Youth Work E-Learning Course' on the National Youth Council of Ireland on or before 01.03.26.	Training schedule completed by manager and reviewed monthly by Director of Services.

		All full-time staff have completed child sexual exploitation training with TUSLA. More substantial training; safe talk (suicide prevention), child sexual exploitation & online and social media safety to be secured with dates on or before 14.03.26.	
	The registered provider must take immediate corrective action as well as ensuring on an ongoing basis that staff are aware of, and acting on their reporting responsibilities in relation to child protection matters, including that mandated persons are acting in compliance with the Children First Act.	Mandated person training completed by all staff on TUSLA- certificates attached. Children's First Training completed by all staff- certificates submitted. Team meeting completed- role of mandated person, DLP and DDLP, reporting process, how to use portal- minutes submitted to inspector.	Weekly team meetings, run through of child protection in each meeting (scenario activities to go through process), child protection reviewed after each incident report. Child protection audited monthly by manager and director.
	The acting centre manager must conduct a full review of all incidents for both young people to assure themselves that child protection concerns have been reported and to take retrospective reporting action if necessary.	Review will be completed and report will be sent of findings by 23.02.26.	Each incident reviewed in line with national standards. (Template submitted)
	The acting centre manager must work	Meetings conducted with Social Worker	Regular weekly contact with social worker,

	collaboratively with the allocated social workers to identify individual needs to implement the necessary robust safeguards as a matter of priority. The registered provider must implement a robust system of oversight to satisfy themselves of the suitability of all care practices and operational policies.	and Guardian ad Litem- safeguarding concerns, daily routine & activities (timetable implemented), safety plans around free time discussed. (13.01.26, 21.01.26). An Garda Siochana Strategy Meeting on 21.01.26- to discuss concerns related to young person. Safety plans implemented around free time. YP engaging with Youth Worker weekly. Implement governance framework and doing a monthly provider oversight meeting, a quarterly audit, biweekly provider monitoring visit. Commencing 16.02.26.	and monthly meetings with GAL and social work team. Implement governance framework and doing a monthly provider oversight meeting, a quarterly audit, biweekly provider monitoring visit.
5	The registered provider must develop and implement the necessary systems to assess the safety and quality of the care being provided in the centre against the *National Standards for Children's Residential Centres*. The registered provider must devise and implement a mechanism for undertaking an annual review of	Introduction of a formal standards self-assessment matrix aligned to all eight national standard themes - one theme done a month at weekly team meetings- self assessment done at the end of the month. Implementation of a structured annual review of quality and safety of care, signed by the registered provider. Establishment	Introduction of a formal standards self-assessment matrix aligned to all eight national standards. Implementation of a structured annual review of quality and safety of care, signed by the registered provider. Establishment

	compliance with the centre's objectives as is required under standard 5.4 of these standards.	of a documented monthly governance and oversight review process, including incident trend analysis, safeguarding review and staffing oversight. Development of a live service improvement plan with clearly assigned actions, responsible persons and timeframes. First improvement plan to be completed 02.03.26.	of a documented monthly governance and oversight review process, including incident trend analysis, safeguarding review and staffing oversight. Development of a live service improvement plan with clearly assigned actions, responsible persons and timeframes. Introduction of a governance dashboard to monitor key quality and safety indicators and identify emerging risks.
	The registered provider and acting centre manager must implement clear and consistent systems and methods of recording in this centre that are in line with centre policy.	The registered provider and acting centre manager have implemented standardised recording templates across all care documentation. Clear recording guidance has been issued to staff in line with centre policy. A monthly recording audit system will be introduced to ensure consistency and quality. Recording standards will be reinforced through supervision and team meetings, and all incidents and safeguarding concerns are reviewed by management. (Fully implemented & practiced by 01.03.26.)	A monthly recording audit system will be introduced to ensure consistency and quality. Recording standards will be reinforced through supervision and team meetings, and all incidents and safeguarding concerns are reviewed by management.

	The registered provider must create a robust policy and practice on significant events. This should include clear guidance for staff on recording and reporting such matters promptly, as well as review and oversight by management.	Significant event policy and procedure- created and will be implemented and staff informed from 16.02.26	Regular reviews of significant events and policy procedure.
	The acting centre manager and staff team should be familiar with all relevant aspects of each young person's placement in this centre. Their individual needs should be identified in placement plans that should be regularly reviewed and linked to all other care planning documents.	Manager and staff team working on placement plans with young people and discussed in-depth at team meetings. Will continue to review.	Regular review of policies and procedures.
	The registered provider must commence a review of the centre policy document and outline a clear plan of completion and implementation, including the provision of training to the manager and staff team.	Action plan attached- 12-week time scale.	Placement plans regularly reviewed in team meetings-oversight from director of services.
	The registered provider must	Maintenance log implemented and	Monitoring visits and audits.

	implement a formal system of property oversight and maintenance with immediate effect. Actions detailed in this report relating to property and fire safety must be addressed as a matter of priority.	attached and checked during director monitoring visits. Fire drill record submitted with new template with amendments as seen in report. Fire assembly picture attached. Bins relocated. Awaiting boiler report from plumber (landlord will provide report). Wall mounted heater will be installed in the laundry room.	
	The registered provider must oversee that the practice of staff working double shifts ceases with immediate effect unless in exceptional circumstances and where an accompanying risk assessment has been developed to inform same.	Double shifts ceased from 16.02.26.	Director of services to review rotas weekly before they are sent to compliance and staff.