An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 112

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Daffodil Care Services Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**17th & 18th of June 2024**
Registration Status:	**Registered from the 17th of May 2022 to the 17th of May 2025**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**30th August 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 17th of May 2016. At the time of this inspection the centre was in its third registration and was in year three of the cycle. The centre was registered without attached conditions from the 17th of May 2022 to the 17th of May 2025.

The centre was registered as a multi occupancy centre to provide care for up to four young people on a short to medium term basis, aged between thirteen to seventeen. The centre operated under a model devised by the company called STEM, a multi system therapeutic model aimed at maximising engagement with young people. The model incorporated a number of complementary approaches including therapeutic crisis intervention, response abilities pathways, circle of courage.
There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
2. Effective Care and Support	2.5
6: Responsive Workforce	6.1
8: Use of Information	8.1

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 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 15th of July 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 31st of July 2024. This was deemed to require the provision of evidence to support the CAPA and the inspector requested that this be provided. The centre manager returned additional evidence as requested including an updated staffing list. This was returned on the 13th of August 2024, the staffing list confirmed that the centre now had a full complement of nine full time staff and a centre manager and deputy manager in post and were now in compliance with the relevant regulation.

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: 112 without attached conditions from the 17th of May 2022 to the 17th of May 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

There were two young people living in the centre at the time of the inspection and their cases were being moved from a child protection social work team to a child in care team, this had resulted in a delay to child in care reviews for one young person. Inspectors found that a plan had been developed to resolve a two-month gap in monthly reviews with two booked to take place either end of the month of June. Inspectors could see clear evidence of how in the statutory reviews that had taken place that the management brought the young people's views and questions to the meetings and advocated for them. A social worker confirmed that through the guardian ad litem (GAL) and the centre manager that they were aware of the key worries and wishes the young people had. They confirmed that they would be developing a plan, with their social work department, to ensure that essential life story work takes place.

Inspectors found evidence of a monthly consultation process with young people which represented a formal opportunity to talk with them about a range of things. These included supporting them to participate in planning. It was evident to inspectors that the output from these was not always reflected in the placement plans as identifiable actions or comments from the young people. It was also clear that there was an inconsistency in the quality of how these were completed, with some being better examples of engagement. The young people were doing activities and sports that they liked and had requested, they confirmed this for inspectors in their questionnaires that they completed for this inspection visit. Inspectors found that the voice of the young people was reflected well in their individualised crisis support plans, so as staff would be aware of and responded in ways the young people identified as helpful.

There were weekly young people's meetings held with the young people and staff signing those meeting minutes. The young people took part and brought items for discussion, decided on plans and these evidenced a positive role the meetings were

playing in the structure and routine for them. The meetings often reflected specifics related to needs, like individual hygiene patterns and inspectors have asked that the team reflect on the purpose of the shared meetings and what the privacy boundaries should be around these. These meeting records did not contain evidence of interaction from the centre management or follow up on various requests at times. Young people's meetings had been taking place in the absence of regular staff meetings and it was not clear how issues were responded to for example maintenance required in their bedrooms. Centre management confirmed for inspectors that items noted had been attended to.

Complaints from young people were being recorded, in two categories, non notifiable, to be resolved at the centre, and notifiable to be resolved in collaboration with social workers or by social workers. Inspectors found that the young people had been informed about how to make complaints and about access to information at young people's meetings in January and May 2024. In their questionnaires for inspectors the young people showed they were familiar with the option to make a complaint, who they could do this with and who they could talk to if they were still unhappy about it later. There were records of complaints made by young people and these were maintained in their file and on a centre manager file. Inspectors found duplicates printed of some records and this must be addressed through good file audit and file management, the centre management must ensure that multiple copies are not kept in several locations. When they are closed the complaints must be stored in full on a young person's care record.

Inspectors found it was harder to track, through the centres individual work records, what actions had been taken to resolve non-notifiable complaints in some instances. The format of the complaint forms were not fully completed as intended. Where the process was fully recorded it evidenced the use of local resolution through establishing the facts, negotiating and looking at agreed solutions. There were records attached to the complaints evidencing follow up with the young people and they were recorded as satisfied in the main. Where they were not happy the next steps were not clearly captured on the records reviewed.

There was a system of register numbers in place for complaints and a separate system of register numbers for significant event notifications where complaints had been notified externally. These did not correlate with each other, dates on occasion were different. The centre manager commentary section was absent on some also. The complaint forms themselves would benefit from a clear section for type, dating and tracking on the front.

During interview the staff were clear about the important role of complaints of all types and of young people feeling heard within that. They were clear about reporting complaints externally but were unsure about outcomes of complaints and how they might be communicated and when to external professionals. The social worker and GAL interviewed by inspectors were happy that the young people were listened to and complaints discussed. The GAL identified that the young people contacted them directly and that in following up with the centre manager that items were well attended to and safe decisions made by the centre.

An audit of complaints had been completed in January of 2024 within this a range of issues for action were identified, these related to recording, tracking and policy knowledge and policy compliance. The audit was closed in May 2024 but inspectors could not see full corresponding evidence of how this was achieved. There was some evidence on record of audit feedback being given to a small number of team meeting attendees. Following this there was intermittent evidence of follow through on the audit. At that time the team meetings were irregular, attended by low numbers due to staff vacancies. There was evidence of follow through at supervision with staff but inspectors found there was a lack of opportunity for continuity with audit actions with the team in relation to complaints due to the lack of team meetings and low staff numbers.

Team meetings are scheduled to be held fortnightly. There were no team meetings held in February and April due to low staff numbers. There were dedicated sections on the team meeting minutes for discussion, tracking and review of complaints but these were not completed routinely in the meetings that were held between January to June 2024.

There was a process for completing exit interviews with young people where they are happy to do. One of the young people who had left the centre spoke to inspectors and said they had an experience of genuine care and support at this centre, with the only harder part being the numbers of short term or agency staff who came to work there.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None Identified**

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	**Standard 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that the records of all types of complaints are well maintained inclusive of type, date, persons addressing, outcomes and young people's views after the process.
- The centre manager must ensure that the team meetings take place within their dedicated timeframes and that they reflect discussion of and learning from all types of complaints.
- The centre management must ensure that knowledge of complaints, rights and good standards of recording and reporting are developed with the full staff team.
- The centre management must ensure that young people's comments and requests are responded to and evidenced in the young people's meeting records.

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.5 Each child experiences integrated care which is coordinated effectively within and between services.

There were end of placement reports completed for the two young people who left the care of the centre since the last inspection. A review of these contained evidence of regular and good collaboration with external professionals and organisations. This included supporting young people to attend important appointments linked to assessment and clinical support. One of those young people was moving into

aftercare and their records displayed evidence of meetings and collaboration towards preparation for leaving care. A young person confirmed that they were very happy with how they were supported by the team during their preparation for leaving care and for the time of the move itself, they said they couldn't praise the team enough.

Whilst the end of placement reports contained narratives about the work undertaken with young people the structure did not identify the author and the date completed. The format, as it was structured, did not support what learning took place from those placements and discharges regarding strengths and areas for development and inspectors found that it would be helpful to review the format. Inspectors reviewed a significant event report of the last day of a young person's placement and this confirmed that they had been given a memory box and a scrap book of their time at the centre.

For a young person entering aftercare there was evidence of them attending their child in care reviews including their final one with their voice and views integrated into the process. There was a copy of their Tusla aftercare plan on file but this was not the signed or updated version. There was evidence of the centre manager following up on asking for a copy of the plan. Inspectors found that the independent living skills work was reflected to an extent on the placement plans, this had increased towards the latter part of the placement. In common with other files at the centre there was evidence of repetition and of calendar entries for key work and actions being left unaccounted for. The team had utilised a company document for assessing and supporting the development of independent living skills. This was used once in June 2023 and inspectors could not see it referred to again before the end of placement in May 2024. It did not evidence how the conclusions were reached or if it had been completed with the young person's input.

There were exit interviews attempted with both young people who had left the care of the centre since the time of the last inspection, one of whom agreed to participate and were happy with the care and support during their time there.

The centre had a policy and set of procedures on the sharing of information and transfer of files back to Tusla upon discharge, young people's files had been returned to Tusla in accordance with the policy.

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

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	**Standard 2.5**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must take steps to address the creation and tracking of key work and individual work actions and goals in preparation for leaving care and general planning for all young people. These should be resourced in line with young peoples age and stage of development and informed by assessments completed.

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.

Inspectors found that staffing had been an ongoing and impactful concern for an extended period of time for this centre. The ACIMS management had received communications from the operational director of the company regarding this centre in February 2024. This outlined the deficits in staffing and described the multi layered initiatives in recruitment and retention that were attempting to correct the ongoing deficits. The short fall in staff continued past February 2024 and were still an issue at the time of this June 2024 inspection, placing the centre in ongoing noncompliance with Child Care (Standards in Children's Residential Centres) 1996 Regulation 7: Staffing - numbers and qualifications as outlined in the 'ACIMS regulatory notice on minimal staffing level and qualification'. Inspectors found that a protective measure taken was the decision to not admit further young people until

the team was restored to full capacity. The centre management estimated that this would not be before August 2024.

The centres September 2023 statement of purpose and function commits to providing three social care leaders, seven social care workers, two relief staff and a centre manager and deputy manager. The list provided for this inspection listed seven staff, in addition to the centre manager and deputy manager, one to be a social care leader and the others as social care workers, two of whom were just starting and listed another two staff due to onboard the team. Over fifty percent of the staff were social care qualified and/or relevant equivalent. The new centre manager had been appointed in April of 2024 from the deputy manager position.

Since the last inspection in May of 2023 two staff remained the same according to the lists provided, one of those being the current centre manager and one social care leader, a third staff joined and a fourth staff member returned from specific leave after just after last year's inspection. This increases the number from two to four. The centre provided the list of nine staff who had left in that period of time. The vacancies on the rosters had been filled from an agency and by some support from other centres or transfers internally within the company. Inspectors reviewed the vetting compliance files provided by the agency to the centre and found that the staff were qualified and vetted but that not all of the files for those working regularly at the centre were present in full. The centre manager must ensure that they review the records for those completing shifts at the centre. The agency staff were not trained in the same named approach to behaviour management and restraint as the centre staff and of five agency files reviewed only one had first aid recorded.

Inspectors did not find evidence that these training differences had been risk assessed now that the staff levels were two staff on duty. There must be a clear risk management protocol in place in order to effectively plan for the day. There had been several different complaints and a child protection referral made against agency staff, all had been addressed, notified to the relevant parties and concluded. The agency involved was informed of and responded to the outcomes of these processes.

The company approach to induction and onboarding of staff did not include completing the chosen method of management of behaviour or the first aid training prior to commencing. These were being booked for staff to attend in the coming two months. The centre manager must ensure that they also risk manage this appropriately until such time as the trainings are completed and the team stabilised.

On a May 2024 internal personnel file audit, there were five social care staff of whom one was a relief staff and one on long term leave four did not have first aid training.

The centre management and regional management teams shared an on-call roster to provide cover for the centre during evenings and weekends.

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	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The organisational management and the centre management must work together to ensure that they adequately staff and train the team taking account of the stated purpose and function and registered capacity of the centre.
- The centre manager must ensure that there is a risk management plan in place taking account of the differences in training between agency staff and centre staff. There must also be a risk management response that takes account of the numbers of staff overall trained in first aid when planning the roster.

Regulation 17: Records

Theme 8: Use of Information

Standard 8.1 Information is used to plan, manage and deliver child-centred, safe and effective care and support.

There was a system of notification of significant events in place, these were logged in a centre register with positives and achievements being reported along with challenging incidents. Complaints were also notified either through the SEN system or when locally resolved through the monthly reports for social workers. Inspectors

found that the system of serial numbers between complaints and SENS did not correlate well and caused confusion during our review, in order to support good tracking and information management this should be resolved.

The centre management team completed significant event reviews, SERG, these were completed using a well-developed template. Inspectors found though that there was no evidence of the SERG process and outcomes being shared at team meetings and staff were not familiar with any recent engagement or outcomes from it. There had been no team meetings held in the months of February and April, team meetings were to be fortnightly. In the months the team meetings did take place, since January 2024, attendance was typically low in numbers due to the low number of full time staff. Therefore, actions to underpin team growth and development were unevenly actioned, for example in knowledge of the HIQA national standards and some of the centre's policies. The team meeting minutes did not evidence review of incidents and did not adequately evidence follow up on complaints.

Inspectors found that there was development work required in recording and tracking of key work and individual work. This included age and stage appropriate resources and thereafter tracking and discussion at regular team meetings. Inspectors also found some evidence of copy and paste in use, of unexplained multiple copies of certain records and the centre management had identified data privacy issues by some staff who used personal email accounts and instructed staff to desist. The centre management stated that they established that no data breaches occurred due to this. Inspectors recommend that training and development is needed for the team on information management.

The staff completed monthly updated practice guidelines for each young person along with reviewing of individual crisis support plans, absence management plans and other relevant plans. There was a structured approach to risk assessment and management and all risk assessments were reviewed within this monthly process. Inspectors found that in these risk assessments the centre team needed to be clearer about what they did to mitigate the risks and how this is reflected on and achieved, so that they identify areas for learning from the risks that have been closed for the young people. The lack of team meetings made it difficult to see how over time the closing of certain risks, like vaping, absconding, were achieved. Both young people were stated by their social worker and their guardian ad litem to be safer and settled in their placement with progression made in education, daily routines with better sleep and nutrition habits. Both young people identified in their questionnaires that

they liked the activities they got to do and to explore with the team. Their main concern was about their future.

The company had provided the ACIMS with a 2024 schedule of audits both internal and external that would be completed. Inspectors found that this schedule was largely being completed in compliance with the time frames outlined. Within the audit templates there was good use of the inclusion of a staff interview section. This assisted in identifying areas for improvement however the staffing changes and lack of team meetings has not been helpful in moving those forward. A sample of supervision reviewed did evidence follow up on performance and on roles and responsibilities. The centre manager must ensure that they discuss the outcomes and action plans from all types of audits with the team and evidence how the actions were being implemented.

The young people had been told about information being recorded at the centre and offered an opportunity to see their daily logs. In their written questionnaires one young person indicated that they knew they could ask the staff or social worker to see information. Inspectors were informed that the parents booklet informed them that records were kept at the centre. Inspectors found that the centre management and staff should review the sanctions process and satisfy themselves as to their fairness and effectiveness in line with the goals for the young people's development and their understanding.

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

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	**Standard 8.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management and regional manager must ensure that recording and file maintenance at the centre is free from copy and paste, duplication and that all staff are fully trained in safe sharing of information and data

protection rules and responsibilities including use of secured online systems only for emails, recording and reporting.

- The centre manager must ensure that they share the outcomes and actions from audits with staff and evidence how key audits were being closed satisfactorily.
- The centre management and staff team must review the sanctions and satisfy themselves as to their fairness and effectiveness in line with the goals for the young people's development and their understanding.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure that the records of all types of complaints are well maintained inclusive of type, date, persons addressing, outcomes and young people's views after the process.	SCM will oversee all complaints and provide feedback to staff team around escalation process. Team meeting on 8.8.24 will review complaints policy and steps to take in escalating to notifiable. The complaints form has been reviewed with clear section added to record date and type of complaint to the first page.	Complaints policy will be reviewed and discussed with each staff member through supervisions and team meetings on a regular basis. Formally brought to staff attention at team meeting on 24.7.24 and 8.8.24. Staff team will be supported in completing complaints as they arise with support from management team. Supplementary supervisions will be completed with staff members as they occur. Only the SCM/DM will log complaints in this register and SEN register to ensure all reference numbers and dates correlate. Complaints Audit will be completed every 6 months as per Auditing Schedule laid out. Regional Manager will complete this again in October 2024.
	The centre manager must ensure that the team meetings take place within	As the centres staffing levels have now increased with staffing risk closed, team	This is now possible due to increase in staffing levels.

	their dedicated timeframes and that they reflect discussion of and learning from all types of complaints.	meetings have returned to fortnightly as per company policy. Since inspection these have occurred on the following dates- 13.06.24 25.06.24 10.07.24 24.07.24 and will continue as per Organisational Policy. Any complaints- notifiable/non notifiable will be discussed as part of each team meeting agenda.	Team meeting dates have been added to the centre roster a month in advance and will take place every second Wednesday. Every effort will be made for this not to overlap with any training dates. SCM/DM will ensure complaint review is completed at each meeting and clearly documented in the meeting minutes. Regional Manager will be in attendance for one team meeting per month where this will also be monitored.
	The centre management must ensure that knowledge of complaints, rights and good standards of recording and reporting are developed with the full staff team.	SCM and DSCM will ensure complaints process is fully understood by all staff members within the centre where Supplementary supervisions will be completed to ensure they are fully aware of full procedure with documenting non notifiable and notifiable complaints. This will be discussed at team meeting on 8.8.24 and brought to supervisions for the month of July and August 2024. Supplementary supervisions will be completed with staff members over August	Supplementary supervisions will be completed with all staff members over the month of July and August to ensure all members are aware of the steps to follow when completing a complaint whether notifiable or non notifiable. One SCL has been tasked with delivering a powerpoint presentation on report writing to the team on 21.08.24 to ensure all are fully aware of the recording expectations. SCM/DM will oversee quality and review of all documents at handover each day.

		2024 to ensure their understanding of complaints process.	Second SCL has been tasked with delivering a powerpoint presentation on the complaints policy and process- 04.09.24 .
	The centre management must ensure that young people's comments and requests are responded to and evidenced in the young people's meeting records.	SCM has fully reviewed all young person's meetings and documented all outstanding actions and tasks – 16.07.24.	SCM and DSCM will complete review of Young Persons meeting every Wednesday following completion of young person's meeting on Tuesday's. Feedback will be clearly communicated and all requests will be responded to in advance of following young person's meetings. Regional manager will review these at each meeting they attend per month.
2	The centre management must take steps to address the creation and tracking of key work and individual work actions and goals, these should be resourced in line with young people's age and stage of development and informed by assessments completed.	Key working calendar will be completed with Key Workers on a monthly basis through placement planning meetings with SCM or DSCM present. Original calendar will be kept in handover files along with final product of Individual work completed per calendar month to ensure this is a live working document. This will be brought to each monthly placement plan meeting with keyworkers having	Staff team reminded during team meeting on 26.6.24 around documents being live reports for each young people where they require regular updates and evaluations. SCM will ensure that key work teams are aware of timeframe on reports being submitted along with IWR's being logged and recorded as they occur while ensuring planned IWR list is reviewed at the end of each month to compare to IWR list

		completed IWR review in advance. One SCW with education/childcare background has been tasked with leading the implementation of recommendations from Educational Assessment received this month for one young person using evidence based resources.	factually completed. All new staff members have been booked on to the model of care training module focusing on Placement Planning process on the following dates- 03.09.24 05.09.24 A refresher course on this has also been confirmed for other staff members/management teams not completing modular training and will take place on the following dates – 16.10.24 23.10.24 One keyworker has been enrolled with Foroige "Real You" training programme which will further support evidence based key working sessions in an age appropriate manner.
6	The organisational management and the centre management must work together to ensure that they adequately staff and train the team at this centre	All new staff members have been booked onto core trainings due to take place over the month of July August and September. SCM will maintain regular contact with	Training Audits and action plans will be reviewed every two months by Regional Manager and filed in the centre External Monitoring Folder. Implementation on

	taking account of the stated purpose and function and registered capacity of this centre. The centre manager must ensure that there is a risk management plan in place taking account of the differences in training between agency staff and centre staff. There must also be a risk management response that takes account of the numbers of staff overall trained in first aid when planning the roster.	Regional manager to flag any staffing challenges or changes to staff team. SCM completes a training audit and action plan every two months which is reviewed by Regional manager and any required trainings are requested from our training partners. The next audit is due for completion by 31.08.24 SCM completed review of training needs on 04.07.24 – 7 staff members currently have FAR training with 5 new staff members requiring this. SCM will ensure a staff member trained in FAR is on shift each day. Upcoming FAR course is fully booked, awaiting next available date from our training partners where these will all be enrolled. Risk assessment already in place for use of Agency staff has been updated on 30.07.24 to reflect them not being TCI trained as standard.	actions will also be overseen by the Director of Governance and Quality Assurance. Any training needs will be discussed at monthly Senior Management meetings to ensure these needs are met as required. Both SCL's have been started on Professional Development Plans where upskilling, training and mentorship is the focus. SCM will link in with preferred Agency if cover is required and risk assess whether staff member needs to be TCI trained at that time. They will be on shift with full time staff member who is trained where only 1 staff member is required for restraint as small child restraint is identified in both YP ICSP . Risk assessment will be reviewed and updated as required.

8	The centre management and regional manager must ensure that recording and file maintenance at the centre is free from copy and paste, duplication and that all staff are fully trained in safe sharing of information and data protection rules and responsibilities including use of secured online systems only for emails, recording and reporting.	Staff team are fully aware of information sharing following team meeting on 26.6.24. GDPR and Cyber safety training has been completed by 9 staff members. 3 staff members requiring this have been booked on this course on 01.10.24. Supplementary supervisions will be completed with x 3 staff following their training in October to ensure they are fully aware of record keeping, professional report writing along with breaches in data.	SCMs access has been synced to incoming centre email account, all emails will be monitored Monday to Friday to ensure there are no emails being sent by staff members from personal accounts. All staff aware of sharing of information following team meeting on 26.6.24. Daily paperwork will be reviewed each morning at handovers to ensure quality is of a high standard and copy and paste/duplication is not evident. Monthly documents overseen by SCM/DM also to ensure this practice is not being used. See above action re Report writing presentation scheduled for 21.08.24
	The centre manager must ensure that they share the outcomes and actions from audits with staff and to evidence fully how key audits were being closed satisfactorily.	SCM will ensure Audits are filled once confirmation is received from Senior Management that actions have been completed and all are satisfied with audits being closed. SCM and DSCM will share Audit information during management meetings	This has been added to all team meeting agendas and will also be overseen by Regional Manager and Compliance officer on a monthly basis. Yearly auditing schedule has been developed and shared with all involved with 3 layers for completion- centre manager, regional

		and team meeting on a monthly basis.	manager and Quality Assurance who complete analysis of Audit outcomes.
	The centre management and staff team must review the sanctions and satisfy themselves as to their fairness and effectiveness in line with the goals for the young people's development and their understanding.	Sanctions have been discussed at team meeting on 24.7.24 where team were reminded of the importance of sanctions matching the behaviour and time frame. Sanctions will be reviewed on a monthly basis and feedback provided to team during Team meetings. Restorative work linked to the behaviour will be considered if appropriate before sanction is implemented.	IWR will be completed with young people should a sanction be imposed where clear rationale is provided for each sanction for the young person's understanding of same. Natural consequences, positive sanctions and restorative work will continue to be implemented in order to develop young person's consequential and reflective thinking.