An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 095**

**Year: 2024**

# Inspection Report

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| **Year:** | **2024** |
| **Name of Organisation:** | **Daffodil Care Services** |
| **Registered Capacity:** | **Four young people** |
| **Type of Inspection:** | **CAPA Review** |
| **Date of inspection:** | **13th and 14th August 2024** |
| **Registration Status:** | **Registered from 30th December 2023 to the 30th December 2026** |
| **Inspection Team:** | **Anne McEvoy**<br>**Joanne Cogley** |
| **Date Report Issued:** | **24th October 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 a corrective and preventative actions (CAPA) review 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 in 2008. At the time of this CAPA review the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions from the 30th December 2023 to the 30th December 2026.

The centre was registered as a multi occupancy service. It aimed to provide short to medium term care for four young people from age thirteen to seventeen years. The centre's model of care was based on a systemic therapeutic engagement model (STEM) and provided a framework for positive interventions. STEM draws on a number of complementary philosophies and approaches including circle of courage, response ability pathways, therapeutic crisis intervention and daily life events. There were four young people living in the centre at the time of inspection.

## 1.2 Methodology

The inspectors examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated 23rd, 28th and 29th August 2023. Inspectors reviewed documentation sent by the provider via email and conducted a visit to the centre on the 13th and 14th August 2024. During the visit, the inspectors observed interactions between the care team and the young people, provided opportunities for each young person to meet with inspectors, conducted interviews with the centre manager, deputy manager, two social care staff and regional manager and reviewed additional centre documentation.

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 13th September 2024. The findings of the CAPA review was used to inform the registration decision.

The findings of this CAPA review had determined the centre to have not implemented the required actions and a compliance meeting was held on the 11th October 2024. Service improvements since the issuing of the draft report were outlined by the service and accepted by ACIMS. It therefore deems 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: 095 without attached conditions from the 30th December 2023 to the 30th December 2026 pursuant to Part VIII, and 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.**

**Issue Requiring Action:**

- The registered provider must ensure the child safeguarding statement and the safeguarding and child protection policy is updated as a matter of priority and satisfy themselves that all staff understand and implement these correctly in practice. Staff must be familiar with the risk assessment on the CSS.
- The registered provider must ensure that there is absolute clarity on who holds the role and responsibility of designated liaison person.
- The registered provider must update the ensure that staff undertake the Tusla e-Learning training on the role of mandated persons in line with the organisations' safeguarding policy. They must update the policy to include the Tusla national policy and reporting procedure in respect of child sexual exploitation and ensure staff undertake this training.
- The registered provider must ensure that where specific vulnerabilities are identified for young people that a robust and co-ordinated response is implemented. Specific safety plans must be devised and reviewed and the direction of social workers followed to ensure appropriate safeguards are implemented.
- The registered provider must ensure that all vetting procedures are in line with organisational policy and safe vetting practices.
- The registered provider must ensure that staff are fully familiar with the whistleblowing policy and their obligations to report poor practice.
- The registered provider must ensure there is evidence of accountability where policies and procedures have not been implemented.

**Corrective Actions:**

- The CSS was reviewed at the team meeting on 26.10.23 and will be reviewed through supervision to ensure the team are familiar with its contents. The safeguarding statement will be updated with the addition of CSE by 03/11/23

and will be discussed at the next team meeting 09/11/23. The team have completed the Tusla's child sexual exploitation procedure training in September 2023 and CSE will be incorporated into all child protection courses moving forward.

- DLP training is being developed for all centre and deputy managers and will be rolled out 27/11/23. A list of roles and responsibilities regarding safeguarding is being developed and will be communicated with all staff on 27/11/23. This will be discussed in team meetings and supervisions, alongside the child protection policy to ensure that all staff are clear about their responsibilities and the responsibilities of the DLP. The child safeguarding statement was reviewed in team meeting 26/10/2023.
- All staff have completed Tusla e-learning training re: the role of a mandated person. Child sexual exploitation procedure training was completed by the team in September 2023. The policy was updated to include CSE and discussed with the team in team meeting 13/09/23. Tusla's child sexual exploitation procedure will be discussed at team meeting with all staff on 09/11/23.
- A full review of young people's risk assessments and safety plans is to occur by the 30.10.2023 by centre management, with all risk assessments fully reviewed to ascertain the robustness of the risk management plan and to encapsulate the identified vulnerabilities for all residents. All risk assessments will be reviewed, updated as required with appropriate consultation with social work departments. Management presence will be in place at daily handover to ensure that risk management and safety plans are fully understood by the oncoming team. Risk management and safety plans will be fully reviewed at team meetings.
- A review of all personnel files will be completed by centre management by 24/10/2023, inclusive of staff vetting. The discrepancy in references has been addressed and is in line with organisational selection criteria.
- Centre management reviewed the centre protected disclosure/whistleblowing policy with the staff team on 26/10/2023 at a team meeting.
- Centre management will continue to communicate any issues regarding staff's adherence to policies and procedures to regional manager and this will be reviewed, and action taken, in line with company policy in respect of accountability.

**Review Findings:**

Inspectors reviewed the child safeguarding statement (CSS) and found that it was updated in November 2023 and again in February 2024. The updated child safeguarding statement included references to risks of child sexual exploitation and was explicit in naming the risks that care staff needed to be aware of to sufficiently care for the young people in the centre. Inspectors found that the child safeguarding statement was discussed regularly at team meetings and in interview care staff were familiar with the risks named on the CSS and were knowledgeable in the signs to be alert for in identifying safeguarding risks. Care staff stated that they had completed training in understanding and recognising child sexual exploitation (CSE) and centre management advised that CSE training was now incorporated as part of the organisations child protection policy. A review of the named modules covered as part of this training did not reference CSE and centre management were advised that the certificates would need to reference this module going forward. The safeguarding policy was updated to include the Tusla national policy and reporting procedure in respect of child sexual exploitation. Inspectors were satisfied that this action from the CAPA was implemented.

Inspectors reviewed the centres safeguarding and child protection policy and found that the policy named both the director of services and the centre's social care manager as the person holding the role of designated liaison person (DLP). Similarly, it named both the director of operations and the centres deputy social care manager as the deputy designated liaison person (DDLP). A list of roles and responsibilities was developed to advise care staff on the responsibilities of each layer of the staff team regarding safeguarding, however in interview, inspectors found that care staff were not clear on the pathways to be taken should they have child protection concerns they wished to discuss. There continued to be confusion regarding the responsibilities of the person holding the post of DLP and DDLP and those additional persons delegated the responsibilities of DLP and DDLP. Inspectors issued correspondence to the registered provider prior to the completion of the CAPA review advising of the continued confusion and the registered provider amended the organisational policy to name the centre managers as DLP and the deputy managers as DDLP.

Inspectors were advised in the CAPA that DLP training was carried out for all managers and deputy managers in November 2023, however a review of the training files, and subsequent verification in interviews with centre management, evidenced that the manager and deputy manager for this centre had completed their training in

October 2022. Notwithstanding the inaccuracy of the CAPA regarding the date training was completed, centre management were very clear on their roles and responsibilities with regards to child safeguarding and the delegated responsibilities given to them from the organisation's appointed DLP and DDLP. By the time the CAPA review process was completed, inspectors was satisfied that this action from the CAPA was in the process of being implemented.

Inspectors reviewed the training records maintained for care staff and found that no staff member had undertaken the Tusla e-learning training on the role of mandated persons despite this being an action identified as being completed on the CAPA. Inspectors found that centre management and senior management were not familiar with this module of training and understood the Tusla e-learning on Children First was the training being referenced in the CAPA. Prior to the completion of the CAPA review, centre management had identified the correct training and was in the process of directing all care staff to complete this training.

Care records for each young person were reviewed as part of the CAPA review process and inspectors found that where specific vulnerabilities were identified for a young person, these were mitigated with robust safety plans, devised in collaboration with the appointed social worker. In interview, centre management stated that safety plans and risk assessments were discussed regularly but this was not recorded on the document themselves and this would need to be recorded going forward to satisfactorily demonstrate that the documents were reviewed. Inspectors did not see evidence that risk assessments were discussed effectively at team meetings. The CAPA action plan identified that there was to be a management presence in place at daily handover to ensure that risk management and safety plans were fully understood by the oncoming team. Inspectors observed the handover meeting on the second day of the inspection and found that while management was present for the handover meeting, they did not participate in the process, and there was limited discussion on risk or safety plans. Inspectors were not satisfied that the handover process was sufficiently robust to ensure that safety plans and risk management was fully understood by the oncoming team. Inspectors found that the centre did not fulfil its own identified corrective action on this aspect of the CAPA.

Inspectors reviewed personnel files and found that the current recruitment process of requesting and verifying references was not sufficiently robust. The verification process had changed since the last inspection and the verbal verification process in place at the time of this CAPA review did not evidence that any aspect of the reference was verified or any questions asked as to the suitability of the candidate for

the position. There was no date on the written reference to indicate when it was provided. Inspectors found that the vetting and reference procedures at the time of the CAPA review were not sufficiently robust to provide safe vetting processes and this action remained outstanding.

Throughout the course of the CAPA review process, inspectors interviewed centre management and care staff as well as reviewing team meeting and supervision records. Inspectors found through a review of supervision records that there were instances of poor care practices that while they were appropriately raised with centre manager, they were raised under the organisation's grievance policy with no reference to care staff obligations under the whistle blowing/ protected disclosure policy. Inspectors acknowledge that the protected disclosure/whistle blowing policy was discussed with care staff in team meetings however inspectors found that in instances of poor practice, there was no practical application of the policy. This aspect of the CAPA remained outstanding.

Inspectors found two instances where policies and procedures were not followed by care staff. One incident related to a safeguarding measure with a young person's phone and another incident related to non-adherence to the lone working policy. The corrective action stated that centre management would continue to communicate any issues regarding staff adherence to policies and procedures to the regional manager. Inspectors did not find evidence to indicate that either incident was sufficiently addressed with the staff members involved, nor was there evidence that these issues were communicated to the regional manager or discussed with the regional manager in supervision. Inspectors found that this action from the CAPA was not implemented and remained outstanding.

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

## Regulation 10: Health Care

## Theme 4: Health, Wellbeing and Development

### Standard 4.2 Each child is supported to meet any identified health and development needs.

**Issue Requiring Action:**

- The registered provider must ensure that the policies relating to health and wellbeing are updated to be more holistic and include mental and sexual health.
- The registered provider must review the practice of locking the second bathroom facility to facilitate its use by the young people and to contribute to a homelike environment.
- The registered provider must ensure that all medical errors are recorded in line with organisational policy.

**Corrective Actions:**

- The registered provider will review the general physical health policy to incorporate the areas of mental and sexual health by 17/11/23. The updated policy will be circulated to all centres for review at their team meetings.
- The second bathroom will remain open for use by both the staff team and young people from 20/10/2023.
- A full review of medication records was completed by centre management team on 27/10/2023. The medication policy will be brought to the team meeting on the 09/11/2023. All medical errors will be recorded in line with organisational policy by the centre manager.

**Review Findings:**

Inspectors reviewed the general physical health policy and found that it was updated to include the areas of mental health and sexual health. There was evidence that this policy was reviewed at a team meeting and in interview care staff were knowledgeable regarding the policy and the importance of these aspects of health. They competently discussed the application of this policy in key work and provided examples to inspectors of its practical implementation. Inspectors found that this action from the CAPA was implemented in full.

A review of centre documents, including audits, found that the regional manager regularly checked to ensure that the second bathroom was open and available for use by both staff and young people. During the CAPA review, inspectors undertook a tour of the centre and found this bathroom accessible for use by all in the centre. Inspectors were satisfied that this action was implemented.

Since the last inspection in August 2023, there was one medical error recorded. Inspectors found that this error was recorded in line with organisational policy and there was evidence that the incident was reviewed and addressed with care staff involved during team meetings and in supervision. Three medication audits were conducted since the last inspection and inspectors found these audits to be comprehensive and robust. Where deficits were identified these were actioned and discussed at the following team meeting. Inspectors found this action from the CAPA was implemented in full.

| **Compliance with Regulation** | |
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| **Regulation met** | **Regulation 10** |
| **Regulation not met** | **None Identified** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **Standard 4.2** |
| **Practices met the required standard in some respects only** | **Not all standards under this theme were assessed** |
| **Practices did not meet the required standard** | **Not all standards under this theme were assessed** |

**Regulation 6: Person in Charge**
**Regulation 7: Staffing**

**Theme 6: Responsive Workforce**

**Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.**

**Issue Requiring Action:**

- The registered provider must minimise the practice of staff moving between centres.

- The registered provider must ensure that there is collaborative team working to support child centred effective care and support. The actions of the internal review should be implemented in full, and the team dynamic monitored closely by senior management.
- The registered provider must ensure the practice of supplementary supervision is reviewed to ensure that it promotes positive learning and development for staff.
- The registered provider must ensure that organisational policy in respect of monitoring and quality assurance of supervision is implemented in full.
- The registered provider must ensure that annual performance appraisals take place for all staff and are recorded on personnel files.
- The registered provider must ensure there is evidence that the regional manager receives formal supervision and appraisal in line with organisational policy and best practice.
- The registered provider must ensure that there is evidence of quality assurance by the dedicated department in operation in line with organisation policies.

**Corrective Actions:**

- Staffing deficits are not a current concern. Current staffing levels are 1 SCM, 1 DSCM, 3 SCL, 7 SCW and 2 RSCW. Staff moving to different centres will only occur where there are emergency situations. Staff may also be moved temporarily in response to risk management plans.
- The quality assurance manager completed a full review on team dynamics on 08/09/2023. This report was reviewed by the centre management team and regional manager in the centre's management meeting on 26/10/23 and an action plan developed and implemented.
- Practice of supplementary supervision was reviewed in the centre's management meeting 26/10/23 to ensure that it is positive and promotes development of staff. Supplementary supervision will only be completed by centre manager or deputy manager moving forward.
- A review of all centre supervisions, both quantitatively and qualitatively will be completed by regional manager January 2024. All findings will be provided to centre management team. This supervision audit will be repeated in the second half of 2024 to ensure actions and learning have been applied.
- A review of staff appraisals was completed by the centre management team on 20.10.2023 and found that all staff have up-to-date appraisals on file as required.

- The registered provider will keep a record to evidence formal supervision that the regional manager receives. The registered provider will also schedule annual appraisals for the regional manager.
- External auditing will continue to be carried out by the regional manager who is external to the centre. Evidence of quality assurance by the dedicated department is demonstrated through the provision of centre monthly reports, review and oversight of senior management themed audits. The compliance officer will continue to ensure that learning from other inspection reports nationally is demonstrated through monthly review of centre documentation and reports e.g. young people being consulted in respect of placement plan review, discussion at team meetings where policies and/or procedures have changed. The quality assurance manager and director of services will continue to review external feedback, organisational learning and implementation of action plans e.g. quarterly meetings to review learning from inspections. The quality assurance team will review its current recording systems to ensure that there is evidence available to support these activities and to demonstrate scheduling, oversight and direction, and ensure that this revision is in place in January 2024. A schedule for auditing for 2024 will also be developed by the quality assurance department and will be effective January 2024.

**Review Findings:**

At the time of this CAPA review, the centre was operating at a staffing deficit resulting in a need for the use of agency staff and staff from other centres to cover all required shifts within the centre. The centre had a centre manager and a deputy manager, one social care leader, one social care worker on a leadership progression programme and five social care workers. A letter was issued to the registered provider on the 16th August 2024 advising that they 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. Inspectors acknowledged that the centre was endeavouring in so far as was possible to utilise the same agency and relief staff to ensure consistency for the young people in the centre. Inspectors identified four agency staff who had been used routinely by the centre in the months prior to inspection. Inspectors reviewed handover logs and rosters and found that there were inaccuracies recorded regarding the care staff who had worked shifts within the centre. A review of daily logs evidenced that the names of agency staff were not recorded on daily logs and a relief

staff member from another centre, who had completed at least two shifts within the centre was not recorded on rosters provided to the inspectorate. Centre and regional management were advised that these inconsistencies were to be remedied to provide an accurate account of care staff who had worked in the centre.

Inspectors reviewed the internal review report generated by the quality assurance manager on team dynamics in September 2023. The report highlighted that significant changes within both the centre management and staff team expectedly impacted on the dynamics within the team. It emphasised the commitment from centre management to address and resolve those issues, and acknowledged there were deficits in terms of recording, both in supervision records and in team and management meetings minutes, which were required to be addressed. Inspectors reviewed samples of these documents spanning the year since the last inspection and found that there were still deficits in recording and analysis of team dynamics. In interview with care staff and management, inspectors were assured that team dynamics was continuously assessed and addressed, however there was little evidence in documentation to support this. A review of one team meeting record demonstrated that there was dissatisfaction amongst care staff and management with regards to cleaning being undertaken in the centre, daily car checks not being completed, tidying up in the garden was not being completed, the individual crisis support plan was not being followed and yet under feedback, within the same team meeting, staff were advised that "all feedback to the centre was positive". Inspectors found that these issues and issues raised in individual supervision sessions were not discussed in relevant management supervision meetings. Due to the absence of sufficient evidence and lack of effective communication amongst management layers, inspectors found that this aspect of the CAPA was not implemented.

The auditing schedule provided to inspectors identified that a supervision audit was to occur once per year by the regional manager. Inspectors reviewed two supervision audits undertaken since the last inspection in August 2023, the first was undertaken in January 2024 by the then regional manager and the second was conducted by the current regional manager in June 2024. While the audits themselves were narrative in nature and recorded good detail, they failed to comprehensively provide an overview of the totality of the documents reviewed. Inspectors found that issues between care team members arising from care practice identified in supervision were not tracked through to supervision with the centre management and through to supervision with the regional manager. In interview, the regional manager was not aware of some issues pertinent to care practice in the centre. While there was an

auditing system established, the process was not robust enough to track deficits found by inspectors.

Inspectors found that the practice of supplementary supervision was also subject to the auditing process. In interview, care staff stated that their experience of supervision was positive and focused on staff development. Inspectors found that for the most part care staff were challenged in supervision to reflect on their practice and interactions with team members, however a support plan put in place to promote positive learning and professional development for one staff member failed to address serious issues regarding adherence to policies and safe care of the young people. This deficit was not identified in the auditing process.

The regional manager provided evidence to inspectors of their supervision with a senior manager. This was occurring on a regular basis with four supervision meetings having been conducted from March 2024 to July 2024. The regional manager started in their role in April 2023 and this was subject to a probationary period of six months. They undertook a probation meeting in October 2023 and inspectors were advised that an appraisal was scheduled to take place in September 2024.

Inspectors were provided with a scheduled list of dates for appraisals with care team members. A review of staffing information evidenced that all staff had undergone a probation meeting six months after appointment to their role and an appraisal was scheduled to take place one year from that date. At the time of this CAPA review only one care staff member had completed 12 months post probation and had completed an appraisal. Inspectors were satisfied that this action from the CAPA was in progress.

Inspectors were provided with a comprehensive planned auditing schedule for the period January 2024 to December 2024. This auditing schedule set out the audits and oversight responsibilities of each layer of the governing managers. Inspectors found evidence of quarterly reviews taking place where there was a focus on identified deficits from the previous inspection of August 2023 and there was evidence that learning from other inspections was shared across the organisation in the management meetings and audits, however this did not result in identified improvements. This was evidenced by the deficits identified as part of this CAPA review process, particularly in relation to supervision records and accountability. Inspectors noted that the quality assurance department focused on reviewing governance reports forwarded to them and did not verify or assure themselves as to the validity of information contained within these reports. Consequently, while

inspectors found that this action from the CAPA was implemented, there is still improvements that need to be made to ensure that systems are more robust.

| Compliance with Regulation | |
|---|---|
| **Regulation met** | **Regulation 6**<br>**Regulation 7** |
| **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 6.3** |
| **Practices did not meet the required standard** | **Not all standards under this theme were assessed** |