An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 139

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Daffodil Children Services Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**28th & 29th June 2021**
Registration Status:	**Registered from the 3rd of August 2021 to the 3rd of August 2024**
Inspection Team:	**Eileen Woods** **Orla Griffin**
Date Report Issued:	**11th August 2021**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance 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 3rd of August 2018. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from the 3rd of August 2018 to the 3rd of August 2021 at the time of the inspection visit.

The centre was registered to provide short to medium term care for up to four young people, aged thirteen to seventeen, utilising a therapeutic support care model devised by the company as a framework for positive interventions with young people. The model combines approaches from a range of evidence based interventions into a framework to form a model known as STEM, systemic therapeutic engagement model. There were three 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
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those

concerned with this centre and thank the young 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 on the 26th of July 2021 and to the relevant social work departments on the 26th of July 2021. 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 9th of August 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 139 without attached conditions from the 3rd of August 2021 to 3rd of August 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

The centre had copies of statutory care plans on file for each of the three young people aside from an updated plan pending from a social work department which had been delayed by the cyber-attack impact on Tusla services. The copies of care plans on file had not been signed by the social workers and should be, the manager must request this when social workers visit in future. The care planning meetings had been convened and supported by the centre, the manager, the key worker and on occasion the regional manager attended the statutory planning meetings. There was evidence of efforts to encourage participation by the young people in their meetings and one of the young people had recently done so. The views of the young people were sought for the meetings by the social workers and records of consultation were placed on their care file alongside the care plan documents.

Inspectors found that the actions agreed from the care plans had been brought forward to the placement plans. Inspectors noted that some decisions without specific persons or funding assigned on a care plan had remained outstanding, for example funding for complex dental work. It is important that decisions made on care plans have those responsible and named timeframes assigned by Tusla at the point of care plan decisions.

The centre developed placement plans informed by the care plans, these were reviewed on a rotation basis monthly by the team inclusive of the key workers and management. The initial placement plan was created within two weeks of the start of the placement to ensure it can be implemented in a timely manner. There were two case managers assigned to convene key work planning meetings, these were taking place on a fortnightly basis and were recorded. Inspectors found that these meetings identified goals and tasks for key workers to add to a key work calendar and planner for the young people. Two of the young people had weekly planners and a third was on a living skills programme and planner. There was evidence that the individual work planner corresponded to the goals of the placement plan and that the young people had been consulted as part of the placement plan review. The formatting of

these case management meetings and what they generated differed in the layout of the documents that supported the prioritisation of goals and should be unified for consistency. The manager oversaw the work of the case managers, who were the social care leaders and reported through the fortnightly governance report to the regional manager on the work completed.

The formal overall placement plan review was at six months. Inspectors found that the placement plan structure incorporated the progress report as well as the placement plan and that each of the previous monthly reports would informed the review at the six monthly intervals. Each of the three social workers were satisfied that the goals of the care plan, assigned to the centre, had been actioned and progression noted in key areas. They stated that the communication with the centre through ongoing calls and emails as well as regular strategy meetings for two young people and preparation for leaving care meetings for another had clarified the goals and objectives.

Inspectors found that the policy, procedures and records for placement planning supported goal development, young person participation and accountability within the centre and externally to the regional manager. The model of care was extensively reflected on all the placement plans and the individual work. There were aspects of the approach to recording that made some of the information harder to track where it came to key working linked to information arising, some goals and regarding clarity on clinical referrals and therapeutic needs. Individual work reports were created by staff, much of these were noted as opportunity led and did not always hold a clear trackable link back to placement plans. On occasion comments or information shared during an individual work was not possible to easily track for action.

In discussion with staff, social workers and manager's the inspectors found that the clinical and therapeutic needs of the young people were in fact known or becoming clearer. Referrals for some pending work from Tusla had been impacted by pandemic and the cyber-attack, for example life story work and the social workers involved outlined their next stage plan for these. There was evidence of links to therapeutic services for young people such as Jigsaw or Pieta House. Counselling had also been sourced and offered to young people. Assessments deemed required to inform planning had been booked and one was commencing at the time of this inspection.

There were records of contact with family and in particular promotion of increased family contact that the centre supported the young people in advocating for. There

were also records kept of social work contact, all the social workers were satisfied that they were updated regularly but noted that more co-ordination around the volume of the contact may be helpful.

Compliance with Regulation	
Regulation met	**Regulation 5**
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 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that the formatting of the case management meetings is unified to support consistency in goal setting for young people.
- The centre manager must review and ensure that individual work reports have a clearly trackable link to the placement plan goals for the young people and that any new information arising in these individual works is brought forward for action.

Regulation 5: Care Practices and Operational Policies

Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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

The centre manager had been in post since the centre opened in 2018 and was qualitied and experienced for their role, they were the named person in charge. They demonstrated leadership through their approach to team development and planning for young people. They provided opportunities for the allocation of roles and tasks

on the team to further develop their skills, all assigned tasks and roles were recorded and reviewed.

All staff members had job descriptions and were aware of their duties and responsibilities, chiefly to improve the quality of life and level of safety for the resident young people. The manager was supported by two social care leaders and they held a monthly internal management meeting to co-ordinate planning and care provision. The social care leaders were the identified persons to cover the managers leave and there were delegation records created for this and for other delegated tasks across the team. Additional complementary training was promoted alongside the completion of mandatory training to support a culture of learning and quality improvement for the benefit of the young people.

There were clearly defined governance arrangements and an organisational map in place that identified the centres place in the regional and national structure of the company. The centre had a dedicated regional manager to whom they reported formally through a fortnightly governance report format. The reporting format has been consistently updated to meet the goals of accountability, safety and support. Inspectors found that the regional manager reported to the senior management team and that this group met on a monthly basis typically, the minutes reflected that the needs of the centre were discussed. The manager met with other centre managers in their region on a monthly basis, this was chaired by the regional manager for consistency in information sharing and good governance. There was evidence of actions and responses from the centre level to the external management structures and responses were recorded on file. There had been regular visits to the centre by the regional manager, daily support and monthly supervision provided to the manager. Senior team members, guided by covid 19 visitor risk assessments for essential visits, had also attended the centre from time to time.

The centre had a funding agreement with Tusla as the contracting body and compliance reports were sent to Tusla on a six monthly and annual basis by the company directors.

The centres policies and procedures had been formally reviewed in 2019 and in 2020. Additional policies had been updated as identified in the interim and examples of these included child protection, managing behaviour and bullying in 2021 to date. Inspectors found evidence that the policies once agreed were circulated to all staff through the manager and discussed at team meetings.

The centre had a risk management policy and set of procedures in place and staff were knowledgeable about the system; N.A.M.E – name, assess, monitor, evaluate. The approach to risk assessment included pre admission and group risk assessments, individual situational risks assessments and plans such as individual crisis support plans and absence management plans. There was a centre risk register in place and the manager reported on risk assessments to the regional manager through the governance report. Inspectors found that there was a co-ordinated approach to risk assessment and management but that there were gaps evident in how those that were current or of highest priority were managed on file and on the risk register as it is presently constructed. The inspectors advised that they could not readily track the status of risk management plans around threats of self-harm and what their current rating was. Similarly, there were incidents of bullying that although addressed were also not clearly trackable through the risk management framework. The risk register structure and the highlighting and updating of live areas of risk should be further clarified for the recording systems.

In the management of response to the covid 19 pandemic the centre had been regularly updated by the company with revised covid 19 contingency plans and covid policy.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager and the senior management team must review the risk register structure for the centre that allows for current risks to be identified and their ratings, review and evaluation included.

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.

The residential centre through its manager and regional manager had a process in place for work force planning and for team development. The manager reported to the regional manager through a fortnightly governance report which took account of all aspects of staffing. The regional manager completed the workforce planning for vacancies, skills and needs directly with the centre and through the company senior management team. The company provided human resources support to organise recruitment of staff and the manager and the regional manager identified the gaps.

The centre had a full allocation of a manager plus eight full time staff, this included two staff at social care leader level. There were two additional relief staff for the centre and the level of staff cover daily was three staff on duty. For the three resident young people this was deemed to be suitable to their needs and their current risks by the management and by the social workers interviewed by inspectors. Inspectors found that the staff team were a consistent core group with an additional experienced staff in the form of a second team leader in post since the last inspection in October 2020. There was a balance of experience on the team and there were competencies evident in the skills implemented by the team in how they aimed to support the young people.

The company had successfully instituted a programme of development towards a social care qualification for relevant staff members. At the time of this inspection a staff member had just completed their additional qualification year and another staff was due to commence this in the autumn intake of 2021. The staff had been supported by the company towards their further qualifications with the provision of supports including study days and flexible rostering. All staff including relief staff were qualified in social care or a relevant equivalent. The rosters were managed by a social care leader and there was adequate cover for annual leave and other types of leave. Training was also accounted for as part of the rostering process in order to promote and support attendance.

The company had a range of staff retention initiatives and staff benefits geared towards supporting good staff retention, these included but were not limited to health benefits, an employee assistance programme, positive feedback and recognition of progression through appraisals and probations. Inspectors did not see that there was a combined staff retention policy and one should be developed to co-ordinate the information on the benefits and supports available.

There was an on- call policy in place and during the pandemic arrangements had been adapted to risk manage staffing, relief staff and on call procedures. The regional manager was aware of the on- call usage and type and nature through the governance report and inspectors recommend that they also from time to look at the records at the centre. There was a senior on call available for critical incidents.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1**
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**

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that the formatting of the case management meetings is unified for consistency in goal setting for young people. The centre manager must review and ensure that individual work reports have a clearly trackable link to the placement plan goals for the young people and that any new information arising in these individual works is brought forward for action.	The manager will ensure that the formatting of the case management meetings is unified for consistency in goal setting for young people. The centre manager will review and ensure that individual work is recorded as planned work and have a clearly trackable link to the placement plan goals for each young person. Any new information will be brought forward to the placement plan goals for the following month.	SCM and Case Managers will review the formatting of case management meetings with the team by 05.08.21, to ensure consistent practice for goal setting in line with placement plans. These will be monitored by SCM and Regional Manager on a monthly basis to ensure a unified approach is in place. SCM will ensure all IWR's are recorded as planned placement goals going forward through enhanced oversight of document review. At scheduled case management meetings and team meetings; any new information arising from individual work will be added to the placement plan.
5	The centre manager and the senior management team must review the risk register structure for the centre that	Risks are reviewed at team and management meetings and where the nature of the risk has changed a further	Risk assessments are evaluated weekly and in fortnightly management meetings. Open risk assessments are outlined on the ICSPP

	allows for current risks to be identified and their ratings, review and evaluation included.	risk management plan is created. Risks are communicated via fortnightly governance reports to senior management who hold an organisational risk register which incorporates ratings, and review at monthly senior management meetings. Open risk assessments are highlighted in each young person's ICSPP and going forward staff will outline on the risk register under the outcome section if a risk is now closed. Senior management will review the risk register structure to ensure that current risks include review and evaluation This will be completed by September 15th 2021	and this will continue to be discussed at each case management, team meeting and management meeting. Senior management will review the risk register structure to ensure that current risks include review and evaluation This will be completed by September 15th 2021