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: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced themed inspection**
Date of inspection:	**06th, 07th July 2021**
Registration Status:	**Registered from 30th December 2020 to 30th December 2023**
Inspection Team:	**Linda Mc Guinness** **Joanne Cogley**
Date Report Issued:	**18th October 2021**

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 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 in 2008. At the time of this inspection the centre was in its fifth registration and was in year two of the cycle. The centre was registered without attached conditions from the 30th December 2020 to the 30th December 2023.

This inspection set out to assess compliance with standards 2.2, 5.2 and 6.1 of the National Standards for Children's Residential Centres 2018, HIQA. Whilst onsite, inspectors expanded the inspection to include standard 1.6 relation to management of complaints.

The centre was registered to provide short to medium term care for four young people of either gender 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 was one young person living in the centre at the time of 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	2.2
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 person, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 16th 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 24th August and again on 2nd September 2021 following requests for further clarification by inspectors. 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: 168 without attached conditions from the 30th December 2020 to the 30th December 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

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.

The centre had a policy which provided guidance to deal with formal and informal complaints. Young people were made aware of the centre's complaints procedure on admission through the information booklet and subsequent keyworking. Families and significant others were also made of aware how to complain and the centre welcomed feedback on service provision by families and professionals.
Inspectors found that in general the young person was listened to and their views were given consideration in aspects of placement planning and daily living. However, inspectors found some deficits in the area of recording and managing complaints.

Inspectors found that the complaints policy had not been updated to reflect best practice in the management and resolution of complaints. The centre manager must ensure the centre's complaints policy is updated and recommend that it is congruent with Tulsa's complaints policy 'Tell Us'. The complaints policy in use at the time of inspection referenced both informal and formal complaints. Staff and management described that informal complaints were dealt with through individual work and were recorded on a register. Formal complaints were processed and were notified through the significant event notification system. Staff and management stated that lower-level complaints were dealt with and resolved in the centre directly with young people. They stated that if three informal complaints were made on an issue it was then escalated as a formal complaint.

Inspectors found however, that this is not what happened in practice and that there was a lack of clarity on how complaints should be managed and what met the threshold for escalation to formal under centre. Inspectors found some complaints of a serious nature were not recorded or were recorded as informal complaints. For example, one young person complained on 25/02/21 about fears for their own and staff safety due to the behaviours of another young person. This did not correlate with any entry on either complaint register and inspectors found that this should have been considered in the context of child protection and welfare as well as utilising the complaints process. The social worker was aware of some of the issues through contact with the centre and visiting to review the care file; however informal

complaints that should have been processed and notified were not formally communicated.

Inspectors found that also that in early 2021 the behaviour of a previous young person had impacted significantly in a negative way on the young person in the centre. While the managers and team had advocated with Tusla to alert them to the issues in the centre a resolution took a significant period of time. It is acknowledged that this was a difficult time in the centre and that the team were trying to meet the needs of both young people. Inspectors found that improvements were required to ensure that the potential harm to this young person was adequately responded to through the complaints, risk assessment and escalation processes. The social worker received monthly progress reports which included frustrations expressed by the young person but they did not receive timely notifications of all complaints that should have been recorded and processed.

Where complaints remained in the informal arena, inspectors could not find evidence of an outcome or if young people were informed that their complaints were upheld and what action would be taken. Inspectors found that there was a significant delay in replacing a broken light in a young person's bedroom which should have been highlighted through external oversight of the centre.

The centre made use of a behaviour modification programme which incentivised young people to complete tasks that were aligned to the goals of the placement plan. For example, they received a small financial reward for emptying the dishwasher, doing laundry or other tasks which might be considered development of independent living skills. Inspectors found evidence across care files, young people's meetings and daily records that young people had expressed dissatisfaction a number of times about aspects of this programme. Upon review of the complaints register inspectors found that this was not recorded as a recurring theme in the relevant section of the document. Staff were not utilising that section of the form correctly and this was not picked up by internal or external management through oversight or auditing. The repeated nature of the complaints should have warranted a review of the system for suitability. Inspectors were informed post inspection that this programme has since been reviewed and was no longer in use.

Complaints were on the agenda at staff meetings however, there was no detail of outcomes to complaints, actions required or evidence of tracking recurring complaints. External auditing of the centre by the quality assurance manager or regional manager did not pick up the issues highlighted by inspectors in respect of

recording and management of complaints. This issue is discussed further under standard 5.2 of this report.

Because some complaints were recorded in the daily logs and were not always input on the centre's complaint register it was not possible to track these in real time. The regional manager stated that they could not review all young people's daily logs as part of their oversight of the five centres in the region. Young people's complaints and frustrations were included in progress reports at the end of the month however, as noted previously, recurring themes were not accurately accounted for and serious complaints were not formally investigated or concluded. The system in place at the time of inspection did not facilitate effective review and learning to improve practice as required.

There was evidence that young people were made aware of supports outside the centre such as the Ombudsman for Children and Empowering People in Care (EPIC).

Inspectors did not see a mechanism for children to provide feedback on the complaints procedure and to review its effectiveness. The centre manager must develop mechanisms for children to provide feedback on the complaints procedure and develop systems to evaluate the effectiveness of the complaints procedure in the centre.

Compliance with Regulations	
Regulation met	**Regulation 5**
Regulation not met	**Not all regulations under this theme were assessed**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**1.6**

Actions Required

- The registered proprietor must ensure the centre's complaints policy is updated and recommend that it is congruent with Tulsa's complaints policy 'Tell Us'.

- The registered proprietor must ensure that all complaints are appropriately recorded, reported, managed, reviewed and investigated.
- The registered proprietor must ensure that the resolutions to complaints are clearly recorded in centre records and on the young person's record.
- The registered proprietor must ensure that there is a system in place to facilitate effective oversight and review of all complaints and that learning to improve practice is identified and actioned.
- The registered proprietor must ensure that they develop mechanisms for young people to provide feedback on the complaints procedure and develop systems to evaluate its effectiveness in practice

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.

Inspectors found that there was an up-to-date care plan on file for the young person and a child in care review was scheduled for the week of the onsite inspection. There was evidence of reviews occurring within statutory timeframes. The young person was invited to attend their statutory review meetings and they participated in one on the day of the inspection. On occasions where young people chose not to attend they completed a young person's review form with their keyworker who then advocated on their behalf.

There was also an up-to-date placement plan on file which had been drawn up by key workers. There was evidence across daily logs and key working records that the young person was aware of their placement plan and was consulted about their wishes. The plan outlined the current issues, specific needs, and the supports required to implement the goals of the care plan. There was a case manager in place to oversee the implementation of placement planning and inspectors could see evidence of planned and opportunity led keyworking and individual work to progress the identified goals. There was evidence that placement plans were regularly reviewed and progress reports were available to assess and measure outcomes. Staff had received training in devising and implementing placement plans and there was evidence that they were discussed at each team meeting with a focus on utilising the model of care.

Inspectors found however, that there were some issues that should have been dealt with through the placement planning process but were not evident on samples reviewed. For example, there should have been a greater emphasis on encouraging the young person to share meals with staff. It was noted that they often took lunch and dinner to their room and ate alone whilst gaming with peers. While this was not an unusual behaviour for the young person, staff interviewed during inspection explained that this had increased when they felt unsafe due to the behaviours of another young person. This was on-going for several months prior to inspection. At the time of inspection, they were trying to discourage this practice now and invite them to spend more time in communal areas. They were also making efforts to encourage the young person to engage in activities both in and outside the centre. However, it was evident that the practice of bringing meals to their room was still being facilitated by the team and should be reviewed again.

Another presenting behaviour of concern was noted in the young person's care file and should have been explored through the placement planning process. However, inspectors could not find evidence of this even though it may have been somewhat related to the young person not feeling safe in the house.

The involvement of the young person's family at the time of inspection was quite limited, however where appropriate, family members were facilitated to contribute to the placement planning process in consultation with the social work department.

Inspectors found that external specialist supports were sourced as required, however this was not currently needed for the young person living in the centre. The staff team were supported by management and the social work department to implement the plans in place. Notwithstanding the issues above relating to paying young people to engage in keyworking, the team generally did this effectively through a relationship-based approach and utilising the model of care.

There was evidence that the management and team worked closely with the supervising social work department to ensure positive outcomes for the young person. Inspectors reviewed inspection questionnaires, care files, and interviewed key management and staff in the centre as well as the allocated social worker. With the exception of issues relating to complaints, there was evidence of effective communication between all parties which included regular phone and email correspondence and professional and statutory meetings. The team advocated on behalf of the young person with the social work department for example when they requested more free time. The social worker confirmed that they received copies of

placement plans, significant events, individual crisis support and absence management plans as well as progress reports. There was evidence that they responded promptly to all correspondence and continued to visit the centre on a monthly basis despite the young person choosing not to engage with them. The social worker they were satisfied that the placement was more able to meet the young person's needs since the other young person moved on and that they were making progress.

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 all relevant issues for young people are included and addressed in placement planning

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.

There was a clearly defined governance system in place, each person interviewed had a job description and they were clear in respect of their roles and responsibilities and that of all layers of management.

Review of internal centre records, care files and governance reports found that external management, oversight and auditing of the centre-had been impacted by the Covid 19 pandemic and did not meet the required standard at the time of inspection. Internal and external managers had much less presence in the centre and this may have contributed to deficits relating to management of complaints and risk in the centre. Inspectors did not find that appropriate alternatives were put in place to ensure that safety and quality of care was adequately assessed.

The social care manager was deemed to be the person in charge with responsibility, and authority for the delivery of service and care. They reported to a regional manager who was responsible for five centres in the region. There was evidence that the social care manager demonstrated good leadership and support to the staff team and that they were accountable for reporting to the senior management team. Review of team meetings provided evidence of guidance and direction to staff in support of their work.

Management meetings took place on a monthly basis and inspectors found that there was good attendance and participation. The STEM model of care, planning for young people, staffing, risk management, complaints, child protection, staff training and health and safety were amongst the items discussed at these meetings. There was also a section to discuss learning from organisational audits or inspection processes. Inspectors found that oversight of complaints and risk at management level did not highlight issues of concern which arose during this inspection and requires priority attention and action.

There was an appropriate focus on policy and procedure review in team meetings. There were regular sessions reviewing updated policies and pop quizzes took place to assist staff knowledge of policies and procedures. While this was a positive move and management and staff felt that it was a valuable aspect of team meetings, inspectors found that this required a better focus on the link between policy and practice. For example, the manager had highlighted issues of concern in the centre whereby some staff had given cigarettes to young people and there were occasions where staff had shared their mobile hotspot with young people. While this was managed effectively and robustly, inspectors found that staff in interview did not identify polices which related to professional conduct, despite a recent review of the code of practice at a team meeting. Also, staff in interview mentioned the grievance policy or the supervision policy as the mechanism for reporting poor practice rather than the whistleblowing policy, and only one staff member identified this in returned inspection questionnaires.

Staff responded to inspection questionnaires and reported that they found the social care manager and senior managers to be accessible and supportive despite a lessened presence in the centre due to Covid 19 risk management. There was evidence of discussions relating to audits and compliance reports at team meetings, however as oversight and auditing was reduced the effectiveness of this was reduced.

There was a system in place whereby fortnightly service governance reports (FSGR) were compiled and sent to the regional manager for review. There was evidence of some correspondence between the centre manager and regional manager about issues arising. While there was a section at the end of the report for commentary by the regional manager there was no evidence of a verification process or evidence of tracking issues from report to report.

Themed audits in line with the National Standards for Children's Residential Centres, 2018 (HIQA) were undertaken by the centre manager with the support of social care leaders. A recent audit which covered themes 2 and 4 on 18/06/21 was provided to inspectors. It is important to note that this was a self-audit check list and report. The regional manager informed inspectors that they spoke with staff and the young person after the audit. However, inspectors found no evidence that the regional manager or the quality assurance manager checked or verified the accuracy of information contained in the audit. For example, the audits note that complaints were all managed appropriately however a thorough review of the records should have highlighted the deficits noted in this report. It was not clear what period the audit covered, and this should be included in all quality assurance reports.

A set auditing schedule for 2021 was provided to inspectors and despite some delay due to Covid 19 it was envisaged that they could cover all themes by the year end. Inspectors note that this related to the internal self-auditing process and did not include audits by the regional manager or the quality assurance manager.

An audit of personnel files had been completed by the Human Relations manager however no formal audits by senior management to assess compliance with National Standards had taken place in 2021.

The regional manager provided a number of quality checks on aspects of operations in the centre which they, or the quality assurance manager, had completed across 2020. There was also an off-site quality check on personnel files in 2021. While these were comprehensive checks with appropriate follow up to assess that actions were implemented, inspectors found it difficult to determine how senior managers were

assessing compliance with all aspects of the National Standards. Inspectors found that the process and format did not facilitate on-going review of compliance with key standards such as child protection, complaints or issues of risk for example. No quality assurance audits were available since November 2020 and the regional manager explained that the checks, communication and support to centre manager was mostly done by email in 2021.

The regional manager confirmed that the company had a service level agreement with Tusla, The Child and Family Agency in place. There was on-going engagement with Tulsa's national private placement team (NPPT) in relation to procurement of services, progress of young people's placements as well as review of admissions and discharges.

Inspectors found significant deficits relating to the identification, assessment and management of risk. The centre had a risk management framework in place for the identification, assessment and management of risk. Staff members interviewed during inspection were clear about how the risk matrix worked. The centre had a number of risk registers including corporate, regional, a centre specific one and a risk register outlining the specific risks for each of the young people placed.

Inspectors found that risk register noting individual risks for each young person was not consistent with known risks identified. Inspectors found that a large number of risk assessments had taken place relating to young people's free time and access with family during the Covid 19 pandemic. Inspectors found that some risks were not accounted for in terms of impact on young people as outlined in the section relating to complaints. There was no risk assessment and safety plan relating to a young person's statement that they were afraid another young person would hurt them or staff.

Also, staffing shortages were considered but mainly in terms of impact on the company. The registered provider must ensure that any risk assessment in relation to staffing must include an assessment of the risks posed to the care of the young people.

Inspectors found that negative and destructive behaviour by one young person was considered in respect of staff retention and the cost of repairing property damage. The entry on the risk register did not consider possible harm to the other young person. This was despite evidence across centre records that there was a clear impact on another young person who expressed fear that they or staff members would be

hurt. The young person's social worker also informed inspectors that their young person was negatively impacted at that time and that they often chose to stay in their room. This issue was noted in team and management meetings however inspectors could not see an adequate responses or actions relating to this issue. Often the response on record was that staff should remain emotionally present and document the young person's voice. There should be greater evidence of communication with social worker and the joint actions taken in response to risk.

Significant events which had occurred, and which identified additional risks for young people were not included on the risk register including, alcohol use, fire safety and absences from the centre. Inspectors did not find a risk assessment relating to alcohol misuse despite an incident of concern. While staff conducted checks on the young person there was no evidence of a risk assessment or risk management plan. Staff did put measures in place to implement checks with the young person outside the centre, however documentation of the process and response to this issue was inadequate.

Another issue relating to fire safety did not result in a risk assessment. A young person had broken a fire sensor and had burnt papers in their room however no risk assessment/risk management plan was evident. The sensor was replaced promptly and individual work was completed with the young person. However, a risk such as potential fire in the centre required a more robust risk assessment and documented response. There was no evidence of evaluation of risk smoking in rooms despite concerns that this had happened on occasion.

The centre manager must ensure that all identified risks for young people resident are included on the risk register and appropriately responded to. There must be robust oversight of risk management in the centre.

The centre risk register noted that restraints were not permitted due to Covid-19 pandemic and the absence of certified refresher training in the physical restraint aspect of the behavioural management model in use. There was a plan to complete this training as soon as possible.

Inspectors found that the internal management structure was appropriate to the size and purpose and function of the centre but that improvements in governance arrangements and processes were required to ensure child centred safe and effective care.

There were arrangements in place to provide cover when the manager took periods of leave. Where managerial responsibilities were delegated to other staff members and a formal record of this was in place as required. There were adequate on call arrangements in place to guide, support and direct staff out of office hours when a manager was not present on site.

Inspectors found that pre-admission risk assessments were carried out prior to admission of new young people to the centre. The social worker for the young person had been consulted about the possibility of a new admission to the centre. This process had considered the risks and potential impact that young people may have on each other. They were satisfied that the centre could safely manage both young people. Inspectors note that the centre statement of purpose was short to medium term however the young person resident was there two years and the social worker informed inspectors they were unlikely to be moving on in the near future. Centre management in consultation with the social work department must assess the risk of any negative impact of short-term placements on this young person and determine an appropriate response.

Inspectors found that there were protocols and procedures in place for the management of the Covid-19 virus. Staff interviewed confirmed the centre had adequate supplies of anti-bacterial products, hygiene equipment, personal protective equipment and that there was an increased cleaning regime in place.

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 registered provider must ensure that there are appropriate oversight, management and governance arrangements in place to ensure child centred, safe and effective care. Where onsite presence in the centre is not possible, there must be appropriate alternative external management, oversight and auditing of the centre to address any deficits.
- The registered provider must ensure that staff are fully aware of key policies such as the code of practice and whistleblowing and how they relate to practice.
- The registered provider must ensure that risk registers consider possibility of negative impact on young people when there are deficits in staffing.
- The centre manager must ensure that all identified risks for young people resident are included on the risk register with accompanying risk management/safety plans.

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 at the time of inspection there was appropriate numbers of core staff employed having regard to the number and needs of the young people resident and the centre's statement of purpose. At the time of inspection, the team was comprised of the social care manager, two social care leaders, and six social care workers. Inspectors found that staff turnover was low, with only two new staff joining the team since 2019. There was one relief staff member who was almost two years in post and another was due to commence the week of the onsite inspection.

The centre manager stated that if required they would recruit to increase staffing if new young people were admitted to the centre and a greater ratio of staff to young people was required. The centre was processing a referral for another young person however the pre -admission risk assessment indicated only a requirement for 1:1 staffing so there would continue to be sufficient staff until a third young person is admitted.

Inspectors found that there had been some instability with difficulty maintaining a team of relief staff to cover periods of leave since the last inspection. The social care manager and regional manager stated there were significant issues recruiting and retaining a core group of relief staff. Two of the dedicated relief social care workers had been offered permanent fulltime positions in other centres within the organisation and another left for personal reasons.

Inspectors found for a period of time, there was not an effective relief panel in place to cover all types of leave. Staff members from other centres in the region were used to supplement the roster. As well as the current staff team who were stable and consistent 12 other people had covered shifts in the centre since December 2020. The social worker interviewed stated that their young person had built excellent relationships with the core staff group but that they chose not to fully engage with staff would not be working in the centre long term.

During the period of February to March 2020 there was a requirement for a ratio of 3:2 staffing in the centre to ensure safety. Inspectors noted that this was a period when staff members exceeded their contracted hours to cover additional shifts. Inspectors were informed by the regional manager that this was part of the Covid-19 risk management response to ensure that staff working in individual pods did not cross over where possible.

A sample of team meeting and senior management meeting records found that workforce planning was discussed and that there was an appropriate focus on recruitment to fill the gaps in relief cover.

Inspectors found that there was a good balance of experienced and inexperienced staff and the roster was organised to ensure there was an appropriate mix on shift. The organisation had made significant progress in implementing initiatives to promote staff retention over the past few years. There was an incremental pay scale, pension entitlements, maternity leave, access to an employee assistance programme, self-care supports for staff, healthcare and a comprehensive training programme. It was also planned to introduce a sick leave scheme.

There was an appropriate on call policy and procedure in place to guide and support staff outside of office hours or when the manager was absent from the centre. During inspection interviews staff members stated that on-call were always available and it was an effective system to provide support in a crisis.

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

Compliance with standards	
Practices met the required standard	**Only one standard inspected against**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Only one standard inspected against.**

Actions required

- The registered provider must there are sufficient numbers of contracted and relief staff at all times to take account of annual leave, sick leave and contingency cover for emergencies.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The registered proprietor must ensure the centre's complaints policy is updated and recommend that it is congruent with Tulsa's complaints policy 'Tell Us'.	The complaints policy was updated by the organisation in July 2021 and shared with the team. It was reviewed in the team meeting on 05.08.21.	Centre manager to ensure that staff are reviewing the policy as per policy review schedule. The regional manager and compliance officer will continue to monitor compliance with the reviewing of policies through attendance at team meetings and reviewing of fortnightly service and governance reports.
	The registered proprietor must ensure that all complaints are appropriately recorded, reported, managed, reviewed and investigated.	The centre manager conducted a full review of all formal and informal complaints on 21.07.21. The findings of this review concluded that although young people were listened to and their voices documented, this was not always escalated to formal complaints and due to this, there were delays in follow up action both internally and externally. This review has identified areas for improvement and the centre will ensure that all issues brought	The organisation's complaints officer will continue to be notified in the event of any formal complaint. In addition, the quality assurance manager will continue to review all formal complaints and liaise with the centre manager where required. The senior management team will continue to provide governance and review of the complaints system through fortnightly service and governance reports review. Themed audits, as scheduled by the quality

		forward by young people are documented and responded to accordingly, including the outcome of the conversation, the response of the young person, and details of additional actions to be taken, if required, including timescales in line with the revised Complaints Policy. The centre manager will ensure that all follow up is recorded in the appropriate report/ forms.	assurance department will be completed as per audit schedule 2021 which will include a comprehensive review of complaints and the documentation of same.
	The registered proprietor must ensure that the resolutions to complaints are clearly recorded in centre records and on the young person's record.	A review was conducted on all complaints on 21.07.21. The centre management team will ensure all complaints noted by the young person are adequately recorded as either a formal or informal complaint and noted in the appropriate register. The supporting individual work report will be on file to highlight discussion, investigation and follow up action in line with the revised complaints policy. On each occasion the young person will be offered to utilise the Tusla "Tell us" portal, should they wish to do so.	The organisational complaints officer will continue to be notified in the event of any formal complaint and all formal complaints will be reviewed by the quality assurance manager. The senior management team will continue to provide governance and review of the complaints system through the fortnightly governance review. Themed audits as scheduled by the quality assurance department will be completed as per audit schedule 2021 which will include a review of complaints and the documentation of same.

	The registered proprietor must ensure that there is a system in place to facilitate effective oversight and review of all complaints and that learning to improve practice is identified and actioned.	The complaints policy was revised in July 2021 and discussed with the team on 05.08.2021. A review of complaints occurred on 21.07.21 and systems put in place to facilitate effective oversight. A further review is scheduled for 21.09.21 to review the effectiveness of the systems and ensure learning outcomes. All complaints will continue be discussed in team meetings, noted in minutes and in fortnightly governance report, submitted to senior management. All formal complaints will continue to be discussed at senior management meetings.	The complaints policy was reviewed in July 2021 to include provision to improve mechanisms to ensure effective oversight and facilitate learning, particularly in the recording and management of informal complaints. Onsite review of centre documentation by senior management, which was compromised due to Covid 19 restrictions, have resumed in full. The senior management team will review centre and young people's records as part of scheduled themed audits 2021. The regional manager and senior management team will continue to review fortnightly service and governance reports and team meeting minutes, ensuring all complaints are discussed and actioned as required. As an additional oversight measure, all complaints will continue to be reviewed by the regional manager and quality assurance manager to ensure that the complaints process is in line with policy and procedure. All feedback will be provided to the centre management for

	The registered proprietor must ensure that they develop mechanisms for young people to provide feedback on the complaints procedure and develop systems to evaluate its effectiveness in practice.	On admission to a centre, all young people are provided with a handbook which provides them with information on their right to complain and the associated process. There are a number of mechanisms currently in place which record the young people's voices. These are, the young person's daily logs, consultation on planning/ access to information, weekly young person's meetings, planned/ unplanned keyworking, and utilising the anti-bullying coordinator through our blue shield programme. All of these avenues are appropriate for feedback on the complaint procedure. The centre will continue to use these avenues for such purposes and document accordingly.	further learning, where relevant. The regional manager and senior management team will maintain a regular review of all mechanisms identified for young people to provide feedback. The regional manager will continue to review the complaints procedure in its entirety through reviewing of complaints forms, fortnightly governance reports, meeting minutes and themed audits. In addition, the centre management team will ensure appropriate feedback is provided to the regional manager if any of the identified mechanisms for young people to provide their feedback are deemed insufficient.
2	The centre manager must ensure that all relevant issues for young people are included and addressed in placement planning	All relevant issues for young people will be documented in placement planning documentation as required.	The regional manager and senior management team will continue to review placement planning documentation, in conjunction with fortnightly service and

			governance reports to ensure all relevant issues are recorded effectively.
5	The registered provider must ensure that there are appropriate oversight, management, and governance arrangements in place to ensure child centred, safe, and effective care. Where onsite presence in the centre is not possible, there must be appropriate alternative external management, oversight, and auditing of the centre to address any deficits.	The centre has robust internal and external management structures inclusive of senior management presence onsite at least one day per week. This consistent onsite presence was compromised as a result of restrictions due to Covid 19. The regional manager, in conjunction with the quality assurance manager, will ensure effective oversight and governance. The senior management team have revised its auditing programme for 2021 to ensure child centred, safe, and effective care. Daffodil Care have also recently committed to revising its centre management structure to include the appointment of a Deputy Manager and a complement of three social care leaders which will assist with the demonstration of oversight and governance. Daffodil Care will ensure that all oversight, management, and governance systems currently in place are being utilised	With the easing of restrictions put in place due to Covid -19, the regional manager has resumed weekly onsite visits to ensure effective oversight and governance in conjunction with the centre manager and quality assurance manager. There are a number of governance systems currently in place to ensure child centred, safe and effective care. A sample of these include weekly onsite presence, monitoring of centre staff practice, weekly engagement with young people, review of daily reporting, weekly engagement with centre staff, attendance at handover meetings, capacity to access centre records through online recording system, monthly regional management meetings, monthly senior management meetings where any issues that require additional support/ escalation are discussed. Placement planning, SEN and complaint oversight and review. Review and completion of fortnightly

		effectively to ensure effective child centred, safe, and effective care.	governance report, along with daily centre contact via the regional manager (and weekly onsite presence) and completion of themed audits as per quality assurance department's audit schedule which has been recently revised to demonstrate more comprehensive oversight and will also utilise the additional resources of a deputy social care manager and a cohort of three social care leaders.
	The registered provider must ensure that staff are fully aware of key policies such as the code of practice and whistleblowing and how they relate to practice.	Senior management will ensure staff are fully aware of key policies. This will be achieved through a schedule of policy review at team meetings in addition to the organisations recent investment in online training. This online hub will further assist staff with demonstrating their understanding of key policies and procedures. Policies will continue to be reviewed in team meetings and these reviews documented in fortnightly service and governance reports and team meeting minutes. The protected disclosure	The regional manager and compliance officer oversee policy reviews completed in team meetings, through the regional manager's attendance at meetings and review of meeting minutes. The regional manager and quality assurance manager will continue with staff interviews which explore policy awareness, as part of senior management themed audits. The provider will ensure that a policy awareness timetable to generated for discussion at team meetings in addition to bespoke online training being made available to staff to further assist with their

		(whistleblowing) policy was reviewed by the staff team in the team meeting on 29.04.21 and was revisited at a team meeting on 20.08.21.	understanding.
	The registered provider must ensure that risk registers consider possibility of negative impact on young people when there are deficits in staffing.	The provider will ensure that risk registers consider the possibility of negative impact on young people when there are deficits in staffing. Timeframe – August 2021	The senior management team will review risk registers as part of scheduled themed audits for 2021 and ensure that any negative impacts on young people are adequately recorded and inclusive of impact on young people when there are deficits in staffing. During site visits the regional manager will ensure regular oversight of registers also. Centre staffing complements are routinely discussed at regional management meetings where any deficits will be identified, and appropriate recruitment will occur. These issues and the potential impact on young people will be included in centre risk register and organisational risk register if required.
	The centre manager must ensure that all identified risks for young people	A review of the centre risk register and young person's risk register was conducted	Senior management will review risk registers as part of site visits and scheduled

	resident are included on the risk register with accompanying risk management/safety plans.	on 20.07.21. Findings of the review were actioned and completed by the centre management team. A risk management review occurred in team meeting dated 22.7.21 and staff knowledge on documentation required and procedure to be followed was discussed. The centre manager will review this on an ongoing basis and ensure this occurs in all instances, moving forward.	themed audits for 2021 and ensure that any negative impacts on young people are adequately recorded within risk registers and risk management plans. Fortnightly service and governance reports will continue to be reviewed by the senior management team to ensure an oversight on the recording of risk management plans. All centre risks will continue to be discussed at monthly senior management meetings.
6	The registered provider must there are sufficient numbers of contracted and relief staff at all times to take account of annual leave, sick leave and contingency cover for emergencies.	A review of the centre risk register and young person risk registers was conducted on 20.07.21. This found that the full-time staff complement was sufficient, and that young people had familiar staff on shift each day and as such were not impacted, due to a deficit in relief staff complement. Staffing deficits have been addressed through ongoing recruitment efforts via the HR department. Centre management and senior management will continue to ensure that the staffing complement for the centre is	The senior management team will continue to monitor staffing levels and ensure a proactive recruitment strategy is utilised. In addition, the organisation is consistently reviewing and revising its staff attraction measures in addition it's staff retention measures.

		sufficient.	