An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 152

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Teach Nua Care Services Ltd**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**26th & 29th November 2021** **3rd & 7th December 2021**
Registration Status:	**Registered from 01st April 2022 to the 01st April 2025**
Inspection Team:	**Joanne Cogley** **Linda McGuinness**
Date Report Issued:	**14th March 2022**

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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 01st April 2019. 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 01st April 2019 to the 01st April 2022.

The centre was registered to provide a family orientated therapeutic model of care. This was accomplished through RAP – response abilities pathways, which provides strength-based strategies for young people. Staff were supportive in responding to young people's needs rather than reacting to their behaviours. Staff also used a social learning theory approach in their direct work with young people. There were three children living in the centre at the time of the inspection. One of these young people was placed outside of the centre's purpose and function and a derogation had been approved for both from the Alternative Care Inspection and Monitoring Service.

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 via teleconference 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 15th December 2021 and to the relevant social work departments on the 15th December 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 10th January 2022. 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: 152 without attached conditions from the 01st April 2022 to the 01st April 2025 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.

At the time of inspection there were three young people residing in the centre, one of whom was placed outside of the centre's statement of purpose. A derogation had been approved for this placement. The inspectors found evidence that statutory care plans for all three young people in placement were reviewed in line with the timeframes set out in the legislation and as required in compliance with the *National Policy in Relation to the Placement of Children Aged 12 Years and Under in the Care or Custody of the Health Service Executive*. There were up to date care plans on file for all residents. Inspectors saw evidence of young people's input into the care planning process through the use of the "me and my care plan" document and through meetings facilitated onsite with their social workers. One young person informed inspectors their statutory review was occurring that week and they intended to attend the meeting. There was evidence to show young people's families attended statutory meetings and provided input into their child's placement through this forum. Social workers for the three young people in placement were complimentary of the work being undertaken in the unit and felt that the placements were meeting the needs of the young people in line with their care plan.

Each young person had a placement plan on file. These were drawn up on a monthly basis by the allocated keyworker and reviewed with the case manager. From a review of placement plans on file inspectors found there to be repetition month on month and did not identify clear individual goals for the month ahead. The monthly placement plan review meetings between case managers and keyworkers focused heavily on administrative and filing tasks as opposed to reviewing the goals of the plan and the approaches or resources needed to achieve the goals. The centre manager should review the placement planning process to ensure that individual, achievable goals are determined and regularly reviewed and updated as part of the placement plan review.

A monthly progress report was provided to all social workers outlining the young person's progress in a number of areas such as education, family contact, social

contact and key working engagement. These reports were detailed and provided a good overview of the progress the young people had made. Inspectors reviewed individual work records and found a number of these to be opportunity led as opposed to being planned in line with the placement plan goals. Inspectors did see evidence of visual aids and worksheets being used to educate young people in areas such as puberty, diet, nutrition and relationships.

Inspectors met with two young people on site and both appeared happy in their placement. One young person informed inspectors that it was very much their home and was not like other residential centres they had been in. They provided good insight to inspectors and spoke very highly of the centre manager and staff team.

All three young people in placement had identified areas of need which required additional specialist support. While some supports had been provided, access to some specialist services had been impacted negatively due to the Covid 19 pandemic. The centre manager, in conjunction with social workers, were following up on waiting lists and alternative services.

There was evidence of effective communication between the centre and social work departments on file. Regular email communication was evident along with all monthly documents being sent to social workers for review. The allocated social workers for the three young people confirmed they were satisfied with communication and they received regular updates from the centre manager. They also confirmed good communication with the staff team and stated any time they contacted the unit all were able to communicate progress updates at any time.

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 review the placement planning process to ensure that individual, achievable goals are determined and regularly reviewed and updated as part of the placement plan review.

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.

Inspectors found that leadership was demonstrated by the centre manager through their on-site presence, attendance at team meetings and handovers. There was clear evidence of their written comments and oversight on documentation that provided guidance and review of approaches to the staff team. Staff members interviewed viewed the centre manager as an effective leader within the centre. The management structure consisted of a centre manager, deputy manager and two social care leaders which was deemed appropriate for the size, purpose and function of the centre. The deputy manager provided cover for the centre manager during periods of annual leave. Inspectors also saw a clear record of delegation of tasks between the management team and the staff team with assigned areas of responsibility and follow up allowing for accountability. Social workers interviewed stated that they were satisfied that the centre was being effectively managed. The director of services confirmed the organisation had a service level agreement in place with the national private placement team and provided regular reports to them on service provision.

The centre had a number of governance systems in place that allowed for oversight and accountability. This included both internal and external auditing systems. The organisation employed the services of an external auditor who completed audits in line with the themes of the National Standards for Children' Residential Centres, 2018 (HIQA) on a quarterly basis. Each of these audits consisted of an opening and closing meeting between the auditor and centre manager that set out the expectations of the audit however there was no written evidence to show that an action plan was created with assigned tasks and a timeframe for completion. Internal auditing was completed by staff members, the centre manager and director of services. These were

completed as quality checks as opposed to audits benchmarked against the national standards. To date this year the director of services had completed quality checks on personnel files, record management, covid, supervision and management meetings. There were tasks assigned following these checks to ensure action was taken however significant deficits in staff vetting identified through the inspection process were not identified in audits or quality checks. This is discussed further under standard 6.1 of this report. The centre manager must ensure a clear action plan is created from external audits and is followed through on.

Policies had been updated in line with the national standards. Staff members interviewed demonstrated knowledge and awareness of policies such as whistleblowing, safeguarding and child protection and induction. Policies formed part of the standing agenda at team meetings, and this was confirmed by staff interviewed however evidence of this was limited and it was not possible to determine what specific policies had been reviewed in team meetings. Inspectors recommend policy discussion is recorded in more detail in meetings.

The organisation had a clear risk management framework in place. Staff members interviewed were familiar with this framework and demonstrated confidence in implementing the framework. This was evident through a review of risk assessments and the centre risk register. Risk was actively discussed in management meetings and social workers interviewed confirmed there were discussions relating to risk on a regular basis. There were a number of dynamic issues within the centre at the time of inspection and social workers confirmed they were satisfied with the management of risk and had joint professional's meetings to ensure a collaborative approach with all parties. There was an on-call system in place for evenings and weekends should it be required. All members of the management team partook in this rota and staff members interviewed confirmed they found it an effective and supportive system.

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	**5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure a clear action plan is created from external audits and is followed through on.

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.

Workforce planning was evident through discussions in management meetings. This was also noted on the corporate risk register with control measures identified to ensure adequate workforce were available to the centre at all times. Rostering was completed in advance and all staff were aware of their hours for the months ahead. The centre staff team comprised of a centre manager, deputy manager, two social care leaders and seven social care workers. Inspectors found all except one staff member were fully qualified. The staff member who did not possess the recognised qualifications had worked in the centre since its opening in 2019 however had not yet provided assurances they were returning to college. This person had not yet received a permanent contract and was on a rolling contract pending the uptake of appropriate education. The centre manager and director of services intended to review this in the new year. Five of the current staff members had worked in the

centre since its opening in November 2019 with the average length of service of the team being seventeen months. The centre had access to a panel of qualified relief staff who were available to work in the centre to cover periods of leave. Presently there were five staff on this panel, four of whom had been recruited in 2021. From a review of 2021 rotas, staffing appeared to have been stable and consistent throughout the year. There had been turnover of two contracted staff members who both left to pursue careers in social work. One social worker highlighted that the young person who had been in placement since the centre opened did feel the effects of staff leaving however their core team and key working team remained consistent. The organisation had a procedure for on call arrangements in the evenings and weekends. Staff members interviewed highlighted this process was effective and they received adequate support if they contacted on call. Arrangements were in place to promote staff retention which included pay increments, team building days and training allowances.

Inspectors reviewed a sample of personnel files and found the recruitment procedures being utilised at the time of inspection were not aligned with the processes set out in the 1994 Department of Health circular on the recruitment and selection of staff to children's residential centres. Interview notes were not available on file for staff members, and when interviewed, a staff member confirmed they had an informal conversation with the centre manager followed by an interview with the centre manager via an online app prior to being offered their job. This is contrary to the organisation's recruitment policy which stated a formal interview must be carried out and conducted by two interviewers. The centre manager must ensure they are carrying out recruitment in line with the organisation's policies and procedures.

Reference checks were found to be of poor quality. Whilst the manager had signed references to say they had completed a verbal verification of the reference, there was no formal process in place and there were no standard questions as part of the verification process. Inspectors noted a number of references were generated from personal email accounts as opposed to registered professional or organisational email accounts. In the absence of appropriate verbal verification, the veracity of these references could not be determined. The centre manager must ensure a formal process for verbal verification of references is implemented as a matter of priority.

Inspectors also found that a number of written references had not been submitted by the intended referees, instead the centre manager had spoken with the referees over the phone and completed the written references themselves. In the absence of written evidence inspectors could not conclude these references were from a valid

source. From the sample of five personnel files reviewed, this was found to have occurred on seven occasions, with only one file having been completed fully and aligned with the requirements of the 1994 Department of Health circular on recruitment and selection. The deficits in recruitment and vetting processes led to a circumstance where a person furnished a reference for a candidate and they were not who they claimed to be. It was confirmed during interview with the staff member that they had agreed with a friend that they would provide a reference and claim to be in a management / supervisory position when they were not. The centre manager did not complete adequate verification checks on this reference to establish that the referee was who they said they were. This has serious implications for child safeguarding. The director of services must satisfy themselves that all staff have received appropriate vetting and provide a full report to ACIMS inspectors when this process is complete. They must also review recruitment and vetting procedures moving forward and implement a plan to ensure the safety of young people in the service. The director of services must ensure the organisations auditing system captures any deficits within the centre and that an appropriate action plan is implemented.

Inspectors noted in one instance disclosures were identified on garda vetting. There was no corresponding risk assessment on file relating to these and the centre manager must ensure this is completed in all instances where disclosures are identified on vetting.

Compliance with Regulation	
Regulation met	**Regulation 6** **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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The centre manager must ensure they are carrying out recruitment in line with the organisations policies and procedures and the director of services must ensure that children are effectively safeguarded through implementation of robust recruitment and vetting policies and procedures.
- The centre manager must ensure a formal process for verbal verification of references is implemented and properly recorded.
- The centre manager must ensure risk assessments are completed in all instances where disclosures are identified on garda vetting.
- The director of services must satisfy themselves that all staff have received appropriate vetting and report to ACIMS when this process is complete. They must also review recruitment and vetting protocols moving forward and implement a plan to ensure the safety of young people in the service.
- The director of services must ensure the organisations auditing system captures any deficits within the centre and that an appropriate action plan is implemented.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager should review the placement planning process to ensure that individual, achievable goals are determined and regularly reviewed and updated as part of the placement plan review.	The current placement plan process includes: -keyworking meeting with the case manager and key workers which discuss: -the division of duties, reviewing ICSP's, IAMP, practice guidelines (inclusive of staff approach), -placement planning; devising calendar of the month including: -keyworking, -appointments, -activities planned for the month and -the outcomes of the month recorded on the placement plan. -The case manager (Social Care Leader/Deputy) record a 'case managers report' outing the completion of above and the delegated duties for the following month. This report is reviewed by the centre manager at the end of each month along with the above-named documents	The centre manager will continue to review the placement planning processes with SCL's/case managers and the keyworking teams to ensure positive outcomes for the young people. The goals for the young people will be of central focus, how these goals are achieved and if further work is required, this will be documented in the case managers report for the centre manager's review. New goals or existing goals which are not met can be populated in the placement plan for the following month if deemed appropriate for the well-being of the young person. The monthly placement plans may seem repetitive due to the age, cognitive abilities and needs of the young people i.e., the young people need a longer period to learn new skills, coping mechanisms, respond and learn from social learning, keyworking

		before being sent to the Social Work Department for there review and feedback if necessary. To improve the placement planning process, the centre manager will: Review the current keyworking calendar, ensuring that the calendar clearly outlines the scheduled work regarding the delegation of administrational duties, the achievable goals for the young people, planned keyworking, activity plan and appointments for the following month, (With a focus on clear goals for the young people). The outcomes for each young person are reviewed at the end of the month, recorded within the case managers report, with a calendar of completed tasks (For accountability of work completed with each young person to meet their needs), appointments and young personal's achievements and goals will be of focus. The young person's achievements/strength's and goals/needs for the following month will be discussed	and respond to staff approach to teach/help them to achieve goals. The monthly placement plan will remain in place and will be reviewed by the centre manager at the end of January, February, and March. If deemed appropriate a 3-month placement plan can be implemented for young people who require this support extending planning to meet achievable goals. The centre manager and the Director of Service will discuss this change in placement planning in April 2020 and decide which is most suitable as per young person's needs moving forward.

		at the co-keyworking meeting and will be populated in the placement plan and placement plan calendar. Commencing 01 February 2022.	
5	The centre manager must ensure a clear action plan emulates from external audits and is followed through on.	The centre manager will review the current system whereby: 'non-conformities are identified and discussed within a closing meeting and then rectified'-no action or time frame recorded at present, just date of completion. A clear action plan inclusive of timeframes will be documented and attached to the closing meeting moving forward. Practice commencing immediately from January 2022. The next scheduled external and internal audit(s) will have written evidence of the action plan and the timeframe for completion of the non-conformities.	The centre manager and Director of Services will review Auditing systems each quarter commencing January 2022 ensuring: - Clear action plans - Clear time frames for completion - And by whom. The current External Auditing tool benched marked off the HIQA 2018, National Standards for children in residential centres.
6	The centre manager must ensure they are carrying out recruitment in line with the organisations policies and procedures and the director of services must ensure that children are effectively safeguarded through	The Director of Services and centre manager will ensure recruitment and vetting is in line with current policies and procedures, therefore ensuring effective safeguarding. By ensuring that:	The Director of Service and centre manager will ensure recruitment and vetting is in line with current policies and procedures. -Ensuring the interview process is in line with policy and procedures, 2 senior

	implementation of robust recruitment and vetting policies and procedures. The centre manager must ensure a formal process for verbal verification of references is implemented and properly recorded.	1. 2 members of senior management will conduct interviews, either in person or utilising online video/teleconferencing. Written record of interview will be filed within staff personnel files. 2. Adding the written record of the verbal verification process i.e., standard questions asked during the verification process. 3. having robust systems in place regarding staff references. i.e., references will be obtained in line with Policies and Procedures. Written references are obtained from recipient via email or post and then verified via call utilising standard questions and retaining a written record of communication. 4. references requested from registered professional's, companies or providers email accounts will be he preferred format, not from other emails such as Gmail/yahoo accounts. 5. asking the employee at recruitment	management personnel conducting the interviews. Written records of interview notes filed within personnel files. -Adding the written record of the verbal verification process. -having robust systems in place regarding staff references, email from recipient, standard questions recorded in written format not just verbal communication. -references from registered email addresses preferred communication. Director of Services will conduct an Internal Audit on personnel files, monthly spot check and record an audit if non-conformities are identified for the centre managers attention and response/action plan and timeframe for addressing any deficits noted. The Director of Service will complete the Quality Assurance Auditing (as per auditing schedules), bench marked against the HIQA 2018, national Standards for children in residential care.

		phase (within written format in email) to nominate their references, their role and if the nominated person had a supervisory role. 6. print the emails from the recipient and attach to the back of the reference form to be stored in the personnel files.	
	The centre manager must ensure risk assessments are completed in all instances where disclosures are identified on garda vetting.	Not only will the centre manager discuss the disclosure with the Director of Services and the appointed staff member verbally, a written communication will be filed in the personnel files (risk assessment form) any follow up or evaluation of risk will also be noted.	A risk assessment will be recorded if a disclosure is highlighted on garda vetting. Reviewing/evaluating risk and follow up if deemed necessary Example: possible training/driving agreement or supplementary supervision. Risk assessments for all current staff will be completed by the Director of Service by 14.02.2022 and all subsequent staff thereafter.
	The director of services must satisfy themselves that all staff have received appropriate vetting and report to	The centre manager will review necessary references, obtain references from registered providers or personnel, print	

	ACIMS when this process is complete. They must also review recruitment and vetting protocols moving forward and implement a plan to ensure the safety of young people in the service.	emails, references, and written verification of standardised questions in the staff personnel files. The Director of Service will review references and vetting protocol to ensure inline with policies and procedures. Director of Services will conduct an Internal Audit on personnel files, monthly spot check and record an audit if non-conformities are identified for the centre managers attention. The centre manager will formulate a response/action plan and timeframe for addressing any deficits noted. The reviewing of said references will commence in January and February 2022. This time frame is based on other providers/personnel returning references within designated time frames. The Director of Service will submit a report to ACIMS no later than the end of February 2022.	
	The director of services must ensure the organisations auditing system	The Director of Services will utilise the Quality Assurance auditing system (based	The Director of Services will utilise Teach Nua's Quality Assurance Auditing System

	captures any deficits within the centre and that an appropriate action plan is implemented.	on HIQA, National Standards for children's residential centres), when completing audits, inclusive of action plan and timeframes commencing from January 2022.	(based on HIQA 2018, National Standards for children's residential centres). An auditing schedule is implemented at the start of the year based the themes/standards being assessed/audited. When/if non-conformities/deficiencies are noted in the audit, the Centre manager will identify an appropriate action plan/time frame to address nonconformities. All closing meetings and action plans will be reviewed by the Director of Services once complete.