An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 028

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Traveller Families Care**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced Inspection**
Date of inspection:	**13th, 14th and 15th March 2023**
Registration Status:	**Registered from 05th December 2022 to 05th December 2025**
Inspection Team:	**Janice Ryan** **Ciara Nangle**
Date Report Issued:	**16th May 2023**

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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 and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 10th October 2000. The centre changed its statement of purpose in 2016 and was granted their first registration under the new purpose and function in the same year. At the time of this inspection the centre was in its third registration and was in year one of the cycle. The centre was registered without attached conditions from 05th December 2022 to 05th December 2025.

The centre was registered as a multioccupancy service to accommodate six young people from age thirteen to seventeen years on admission on a short term basis. It provided care and accommodation for separated children seeking international protection in Ireland. Their model of care was described as a needs-based model that was implemented through the application of Maslow's Hierarchy of Needs that included psychological, safety and security, belonging and love, self-esteem, and self-actualisation. There were six 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
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 seniormanagement 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 31st March 2023 and to the relevant social work departments on the same date. 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 09th April 2023. 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: 028 without attached conditions from the 5th December 2022 to the 5th December 2025. pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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 had a clearly defined governance structure in place which was updated to reflect the appointment of a full-time deputy manager and social care leader roles. The centre manager confirmed that they reported to the Director of Services (DOS) who then reported to the Board of Management. The centre was providing care to six young people and the inspectors found that the recent change in the internal structure would support the centre manager to provide better governance and oversight in the centre. The centre had an appropriate service level agreement in place with the Tusla Child and Family Agency.

Oversight and governance mechanisms were in place externally and internally in the organisation. The presence of external management (DOS) visiting the centre to provide oversight was clearly visible. Whilst on site the inspectors found clearly documented and comprehensive oversight from the DOS through a review of centre and young people records. The inspectors found that all young people had up to date care plans in place except for one young person who had a recent Child in Care review. The inspectors found evidence that when a care plan was outstanding the centre manager utilised the escalation procedure to request same and this was in turn followed up by the DOS where required. Inspectors found that the DOS was fully aware of all aspects of the running of the centre and they completed regular visits and attended staff team meetings. At times however, they were endeavouring to have a less hands on approach in the day to day running of the service. The DOS must continue to ensure that their role remains in overseeing the delivery of care, the review of operational policies and procedures and assessment of compliance with the relevant regulations and national standards. Continued improvement in this regard is required. The inspectors found that all visits to centre by the Director of Services were not recorded which was a safeguarding issue. This should be completed as this was a finding in the previous inspection report.

From a review of centre records, it was clear that the centre manager was providing good leadership and was available for support and guidance to the team. A regular schedule of management meetings was in place to address deficits in the organisation and running of service. Team meetings were in place which included standing agenda items and records of discussion reflected this agenda.

Oversight and support were provided to the centre manager by the DOS and took place in many different meeting forums combined with onsite visits and supervision. Supervision was in place in the centre however, in recent months the inspectors found that supervision was not in line with policy. On review of a sample of staff supervision records they found that they were brief and contained limited information in relation to personal development and case management and improvement was required in this regard. On review of the centre manager's supervision records they found it had improved since the last inspection and included discussion around oversight and running of the centre. However, the inspectors found the tracking of actions completed required improvement.

The centre manager was the person in charge in the centre and they had overall responsibility for the day to day running of the service. The organisation had completed a review of their policies and procedures in December 2022 and had aligned these to the National Standards for Children's Residential Centres, 2018 (HIQA). On review of the staff team meeting minutes the inspectors found that individual policies were being discussed and reviewed as part of these forums. The tracking of actions following team meetings required improvement to ensure these are completed in a timely manner. Staff in interview had a clear understanding of their responsibilities as a mandated person. However, on review of the centre's complaint and child protection register the inspectors found that child protection and welfare concerns were being recorded both as a complaint and as a concern. The centre manager must review this process and ensure all concerns are categorised and recorded correctly in line with the organisation's policy.

A risk management framework was in place in the centre which included the use of a scoring risk matrix. The centre held three types of risk registers: an organisational register, centre register and a young person's register. These registers contained open and closed risks with the relevant risk assessments in place. Ongoing monitoring of risk was noted in relation to open risks. The inspectors reviewed the centre's risk register and associated risk assessments and found that improvements were required. The risks assessments and the corresponding risk rating matrix that the centre was utilising did not accurately reflect the level of risk and these need to be reviewed to

ensure that risks are properly rated and the control measures in place are aligned to the risk rating.

Risk was discussed at external management meetings and through case management at staff team meetings. Oversight of risk was provided at many different levels from the centre manager to the DOS and Board of Management. The inspectors found that some risks had not been categorised or assessed for example the turning on of bedroom alarms which was a restrictive practice. The inspectors found that issues in relation to risk was a feature of the last inspection however, the inspectors found that although improvements had been made there was further improvements required to ensure that all risks were correctly identified and assessed, risk rated and the correct control measures were put in place and were robust to manage the risk.

The centre was in the process of implementing a new audit system which was in the early stages of implementation following the last inspection. The DOS stated that audits would be completed on a monthly basis under each theme of the National Standards for Children's Residential Centres, 2018 (HIQA) and it was envisaged that the full cycle would be completed by the end of July and the review process would start again. Following each audit completed the DOS completed a compliance report which was sent to centre management. The inspectors reviewed this report and found it provided more of a detailed overview. However, to be effective it requires more detailed analysis and also actions identified need to be tracked to ensure they are completed in a timely manner.

The inspectors found that the centre manager was also completing monthly audits in the centre. On review of one audit under Theme 5.3 and 2.1, inspectors found deficits highlighted in this report were also highlighted in the DOS audit too with actions identified. However, on review of a medication management audit it noted staff required training but the inspectors found no associated action plan to mitigate this risk. On review of individual Crisis Support Plans (ICSP) for all young people the inspectors found that the date of birth was incorrect for one young person and this had been signed off by the keyworker, centre management and DOS with no one noting same.

The inspectors noted that auditing was an issue in the previous inspection report and although the external/internal auditing process was in its infancy it still requires improvement, as there was no sign off for completion of allocated tasks or a mechanism for recording management oversight of these audits which in turn may lead to issues around the follow up verification process.

The inspectors reviewed a recent report created for the board of management and found that learnings from the previous inspections had been implemented in relation to the specific content that was contained within these reports. These reports provided a general oversight of the running of the service and care of young people and improvement in these reports were found.

Inspectors found that significant event review meetings took place in line with policy on a monthly basis. The inspectors found that there was a rise in incidents for the centre due to the admission of six new people over a very close period of time. The inspectors found that complaints, child protection and significant events were reviewed and monitored at this forum. There was evidence of identification of key learnings, post crisis responses and analysis of effective and ineffective strategies to reduce risk. The inspectors found that that learning from significant event reviews was not always documented as part of the staff team meetings and improvement is required.

The centre had a delegation record in place which listed areas of responsibility and tasks for the social care workers, social care leaders, deputy manager and social care manager. They also had a delegation log in place that recorded tasks required to be completed in the absence of the centre manager.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**None identified**

Actions required:

- The registered provider must ensure that the Director of Services role remains in overseeing the delivery of care, the review of operational policies and procedures and assessment of compliance with the relevant regulations and national standards.

- The registered provider must ensure that actions arising from inspections processes are implemented in a timely manner.
- The registered provider and centre manager must ensure that all visits to centre by the Director of Services is recorded accurately to ensure good safeguarding practices.
- The registered provider must ensure that the risk management framework is reviewed taking account the findings of this inspection.
- The registered provider must ensure that all employees receive ongoing training in the centre's Risk Management Policy to ensure the ongoing identification, assessment and management of risk is effective.
- The registered provider and the centre manager must review the centre's complaints and child protection register to ensure that all concerns are categorised and recorded correctly in line with the organisation's policy and Children's First, 2017.
- The registered provider must ensure that an annual audit schedule is put in place which is aligned to the National Standards for Children's Residential Centres, 2018 (HIQA).
- The registered provider must ensure that audits completed and identified action plans are put in place which are reviewed and tracked to ensure completion of actions. This needs to be demonstrated across centre records.
- The centre manager must ensure that learning from significant event reviews is formally recorded and discussed at the staff team meetings.
- The registered provider and centre manager must ensure that supervision is completed within the required timeframe in line with the organisations policy.

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 the responsibility of the DOS who had managerial oversight of three services operated by the organisation. The organisation discussed workforce planning in a range of forums for example the board of management meetings, external and internal management meetings and at the staff team meetings. On the

day of inspection, the centre had two new staff members who were in the process of completing their onboarding with the organisation.
The inspectors sampled a range of different meeting minutes and found that workforce planning was consistently discussed which included what recruitment actions were required. Staffing difficulties were discussed on a regular basis and the inspectors found evidence that requests for additional staffing and additional funding being sought alongside possible control measures to be put in place should staffing not improve.

At the time of the inspection the centre was operating with one social care manager, one full time deputy social care manager, two social care leaders and 8.9 wholetime equivalent posts which included some staff members on banded hours contracts). The deputy manager and two social care leaders were recently appointed, and these positions were in the early stages of being imbedded within the new internal management structure. The centre had a relief panel in place which was sufficient for the size and function of the service.

In interview with staff and from a review of a sample of personnel files and centre records the inspectors found that staff had the necessary experience and competencies to meet the needs of the young people living in the centre. This was also corroborated by two social workers who had responsibility for four young people residing in the centre. They stated that staff were attentive to the young people's needs and had a good understanding of their different cultures and backgrounds that they came from. The inspectors spoke with three young people all of which corroborated that staff were very helpful in the centre.

The centre implemented a daily roster pattern of two sleep over shifts, one day shift from 10am to 10pm and in recent months had been funded through the social work department for an additional day shift which commenced at 2pm in the day until 11pm at night. The inspectors found that the centre had gone through a difficult period for the month of February in which there had been five staff members absent from the centre due to unexpected Covid 19 leave and sick leave. On review of a sample of rosters the inspectors found that there were times that the centre was unable to fulfil the fourth person on shift due to a lack of agency staff and vacancies within the core team. This resulted in at times centre management and the DOS completing a shift in the centre. The centre manager confirmed that this was not ideal and this risk was recorded on the centre's risk register. Deficits were highlighted in previous reports in relation to staffing however, the centre had made improvements in this regard with the allocation of additional funding to support

additional staffing. The centre envisaged that they should have a fully compliant roster and staffing in place by the end of April 2023.
The inspectors found on review of the young people's daily logs that they captured all staff present in the centre including management and housekeeping personnel. However, they did not specify the roles within the logs and the inspectors found that this may create an illusion of staff in student, management or housekeeping positions completing shifts in the centre. This recording needs to be rectified for safeguarding purpose. The centre must review this system of recording for safeguarding purposes to ensure that staff working with young people are recorded correctly.

Ongoing issues outside the centre relating to pay terms and conditions and pensions had contributed to low staff morale and frustrations over the past year. However, the centre management continued to attend relevant meetings with the funding bodies in relation to same. Inspectors found evidence through a sample of supervision records that this was being discussed. The DOS confirmed that issues in relation to pensions for staff were also a contributing factor to these frustrations.

The organisation had a policy for staff retention which included a list of staff incentives however, the organisation was limited due to the budgetary constraints. The DOS confirmed that they hoped to have team building days outside of the centre which would be funded from their own budget to improve morale in the service.

The centre reviewed a sample of personnel files and found that some documentation was not up to date or on the file. Garda vetting was in place for all staff members. The inspectors found that training records did not correspond with the training register and certificates were missing from some files. On review of the centre training register the inspectors found that some staff had not completed training in some mandatory trainings for example Tusla's Children's First: National Guidance for the Protection and Welfare of Children, 2017 eLearning, Manual Handling and Medication management. The centre manager confirmed that these trainings were schedule over the next three months in the centre. The inspectors found that this risk had been identified and placed on the centre register to address this issue. The centre manager must ensure that mandatory training is up to date for all staff. They must also review the staff personnel files to ensure they contain all relevant and up to date information.

The centre had an on-call policy in place for the organisation. The on call was shared between the social care manager and deputy social care manager. With the appointment of two new social care leaders it is anticipated that these will also

support this function. The centre had an on-call register in placed which recorded information in relation to the direction given.

The centre had no formal exit interviews in place for when staff moved from the service. The inspectors recommend that this is put in place as it is important element in providing feedback either positive or negative on working in the organisation.

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 were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards were assessed**

Actions required

- The registered provider must ensure that there is sufficient staffing in place to meet the needs of the young people in the centre.
- The registered provider and centre must ensure that all documentation is held on personnel files for all staff working in the centre.
- The registered provider and centre manager must review the system of recording of staff for safeguarding purposes to ensure that staff working with young people are recorded correctly.
- The registered provider and centre manager must ensure that all staff have completed mandatory training.
- The registered provider must ensure that there is mechanisms in place to receive feedback on the organisation when staff move from the service.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider must ensure that the Director of Services role remains in overseeing the delivery of care, the review of operational policies and procedures and assessment of compliance with the relevant regulations and national standards.	Clear roles and responsibilities are in place for the centre manager and Director of Services. The Board of Management (BOM) will continue to oversee the Director of Services in her role and ensure that her job specification is being fulfilled.	Continued discussions at the BOM meetings, Supervision and management meetings will assist in solidifying roles and responsibilities for all.
	The registered provider must ensure that actions arising from inspections processes are implemented in a timely manner.	All actions arising from inspections have been implemented or are in process with clear timelines.	The Director of Services will ensure review of the CAPA confirming that any actions arising from inspections are implemented and closed out.
	The registered provider and centre manager must ensure that all visits to centre by the Director of Services is recorded to ensure good safeguarding practices.	Effective immediately the Director of Services signs into the visitors' book highlighting the purpose of her visit.	Continued monthly monitoring of the visitor's book by centre management to ensure recording is taking place.

	The registered provider must ensure that the risk management framework is reviewed taking account the findings of this inspection.	The risk management framework has been revised following our inspection. It will be brought to the BOM on the 24/04/23 to be discussed.	Discussions at Team Meeting, Management meetings and BOM meetings will continue to ensure the risk assessment framework is meeting the needs of the Centre.
	The registered provider must ensure that all employees receive ongoing training in the centre's Risk Management Policy to ensure the ongoing identification, assessment and management of risk is effective.	Once the BOM have ratified the new risk matrix, training will be scheduled for the organisation and rolled out by the end of May.	Management team to oversee the review of the risk management policy and ensure it is being discussed regularly. This will be noted in team meeting minutes and communicated in supervision with the staff team.
	The registered provider and the centre manager must review the centre's complaints and child protection register to ensure that all concerns are categorised and recorded correctly in line with the organisation's policy and Children's First, 2017.	Children's First e-learning has been completed by the team since Inspection. Inhouse complaints training is scheduled for the 19th of April.	Continued review of policies and procedures at the team meeting with oversight from the management team.
	The registered provider must ensure that an annual audit schedule is put in place which is aligned to the National Standards for Children's Residential	The Director of Services is completing monthly audits in line with the National Standards for Children's Residential Centres, 2018 (HIQA) while this process is	A schedule of auditing by the Director of Services is in place. This schedule will also include verification of actions completed where areas for improvement have been

	Centres, 2018 (HIQA). The registered provider must ensure that audits completed and identified action plans are put in place which are reviewed and tracked to ensure completion of actions. This needs to be demonstrated across centre records. The centre manager must ensure that learning from significant event reviews is formally recorded and discussed at the staff team meetings. The registered provider and centre manager must ensure that supervision is completed within the required timeframe in line with the organisations policy.	in its infancy it is occurring. The centre is utilising an auditing tool based on the National Standards and the organisations policies and procedures has been implemented which includes actions identified and assigned timeframes. Effective immediately a new section has been added to the team meeting minutes for feedback from the significant event reviews to be formally discussed. Supervisions are back in line with the organisations policy following significant sick leave within the Centre. We will continue to note on supervisions the rationale as to why it is late and not on the scheduled due date.	identified thorough inspection process. The Director of Services will ensure continued review of the auditing tool to ensure high quality standards of care are maintained through consistent auditing of the centre. Centre management to oversee giving feedback to the staff team following the monthly significant event review meeting. A supervision tracker is in place to ensure supervision remains within the correct timeframes.
6	The registered provider must ensure that there is sufficient staffing in place	Since April and the onboarding of staff we have had sufficient staffing in place to	Centre Management and the Director of Services will continue to review the staffing

	to meet the needs of the young people in the centre.	meet the needs of the young people in the centre.	levels in the centre on an ongoing basis to ensure that there are sufficient levels and that a stable team is in place.
	The registered provider and centre must ensure that all documentation is held on personnel files for all staff working in the centre.	A recent personnel file audit highlighted documentation which was required, and this will be in place by the end of May 2023.	Personnel file audits will take place twice a year to ensure all documentation is in place and in date. These audits will be completed by centre management and another by the Director of Services.
	The registered provider and centre manager must review the system of recording of staff for safeguarding purposes to ensure that staff working with young people are recorded correctly.	Effective immediately from feedback on our inspection only individuals working the overnights and day shifts are being recorded on the daily logs.	This will be monitored by centre management when reviewing the logs to ensure compliance.
	The registered provider and centre manager must ensure that all staff have completed mandatory training.	A training schedule is in place for all mandatory and additional training for the year. All the team will have all necessary training by the end of May 2023.	A training audit is in place and will be updated quarterly to give a clearer oversight on training requirements that need to be scheduled.
	The registered provider must ensure that there are mechanisms in place to receive feedback on the organisation	Centre manager or Director of Services will complete exit interview with staff leaving the service.	All exit interviews will be brought to the BOM with feedback received.

	when staff move from the service.		