An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 052

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Sorcha Homes**
Registered Capacity:	**Six young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**20th ,21st & 23rd May 2024**
Registration Status:	**Registered from 6th December 2021 to 6th December 2024**
Inspection Team:	**Lisa Tobin** **Lorraine Egan**
Date Report Issued:	**6th August 2024**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of 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 6th of December 2009. At the time of this inspection the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from 6th of December 2021 to 6th December 2024.

The centre was registered to provide medium to long term care for six young people from age thirteen to seventeen years on admission. The purpose and function of the centre changed since the last inspections in May 2023. The centre now supports young people who come under the care status of separated children seeking international protection (SCSIP). The centre worked from the Welltree model of care, whose goal was that each young person is protected, respected, and fulfilled. The model was trauma informed and encompassed attachment theories with a focus on challenge and support. 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
1: Child-centred Care and Support	1.1, 1.4
5: Leadership, Governance and Management	5.2

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

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

concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 1st of July 2024. 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 12th of July 2024. This was not deemed to be satisfactory and the inspection service received a second CAPA on the 17th July 2024 with 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: 052 without attached conditions from the insert date 6th of December 2021 to the 6th of December 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 11: Religion
Regulation 12: Provision of Food and Cooking Facilities
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.1 Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child.

Inspectors found that there were systems in place to ensure that each child experienced care and support regarding their diversity and their rights. However, there were further improvements required around ensuring that young people were well informed and clear about what their entitlements were. It was evident to inspectors that the young people received good care from the staff in their everyday lives and were being supported in achieving improvements in their education and in their adaption to living in this centre. Two young people that spoke with inspectors spoke highly of the centre and the supports they were receiving. They stated they were happy and safe and were aware what was expected of them living there and knew they could speak with staff if they had any issues or concerns. Questionnaires were completed by all young people which again provided positive feedback for the most part on aspects of their lives. There were unresolved issues for some of the young people regarding fairness of established rules, for example, allocated time out of the centre, and they required quicker resolution to some dissatisfactions that had occurred. These issues had been forwarded to centre manager for follow up.

The young people received booklets during their admission process which highlighted their rights including information on the United Nations Convention of the Rights of the Child and explained what they could expect from their placement. The inspectors received an English version of this booklet, and the young people received it in their native language. Inspectors found that the booklet was detailed, long and gave information on the young people's rights. It referenced the HSE rather than Tusla as the state body which needs to be updated. Three young people highlighted in their questionnaires that they weren't aware of their rights. Inspectors recommend the staff revisit the discussion with young people about their rights and if necessary, use a translator to ensure they understand the information given.

The young people participated in weekly meetings together where there was a set agenda with opportunity to discuss shared living, any issues or concerns, sharing of information, groceries, respect for house rules and routines and holiday activities. The young people were vocal in areas where they were not happy, as mentioned above, which also included other areas such as bedtimes, pocket money, and inequality around curfews. The minutes did not give clarity on whether these issues were resolved, as it showed some issues continued as they were repeated in later months. The centre manager must ensure that there is evidence to show how the issues raised by the young people were responded to. In the sample of young people's meeting minutes reviewed, inspectors did not see evidence that young people were informed of Empowering People in Care (EPIC), of the ombudsman for children or about how to make complaints.

Inspectors found that all the young people did not have up to date care plans on file. There was evidence of one child in care review (CICR) occurring for one young person since all six were admitted to the centre between November 2023 and March 2024. There were centre minutes on file for one CICR that occurred in March 2024 and the young person attended this. Another young person in care on a voluntary care agreement did not have an allocated social worker and was resident there since November 2023 with no care plan or no CICR taking place. This issue was escalated by the centre manager to the social work department. The social care worker that spoke with inspectors regarding this stated they had escalated this to their team leader and principal social worker. Due to deficits in resources, a social worker has yet to be appointed. The social care worker informed inspectors they have not been able to visit the young person in the centre due to their own caseload and demands, that they received weekly reports about the young person and felt that from those documents, that they relayed that the young person was getting on well. The inspectors informed the social care worker of some findings from the inspection such as upset regarding changes in absent management plans and to the house rules and disclosure of personal information which they were unaware of, and they planned on making a visit to the centre as a result of this.

Inspectors found that with the lack of care plans and no other centre minutes on file, there were difficulties in how staff were guided to prepare the placement planning goals for the young people. The centre worked off the Welltree model and based their placement plans off the associated headings and there were action plans linked to each placement plan.

Inspectors found that there was good support for the young people around their cultural identity and their religion. The young people often cooked for each other, sharing meals together and the staff ensured the young people had the correct foods to cook their meals. The young people were supported in attending the mosque when they wanted to and provided with what they needed for their prayers. Appropriate supports were given to the young people during Ramadan and was celebrated at the end with their friends. The staff team had completed different pieces of shared learning to enhance their knowledge of Ramadan to ensure they could best support the young people. The young people were informed of cultural celebrations in Ireland and were offered to celebrate these occasions too should they wish to. One Guardian ad litem (GAL) spoke of how the team supported the young people with their cultural needs and marked Eid at the end of Ramadan.

As mentioned earlier there were issues raised by the young people around inequality in curfew times between males and females. This was due to be addressed by the centre manager. The young people's individual crisis management plans (ICMP's) were reviewed by the inspectors and also found areas of inequality around interventions named. There was an email from one young person's (GAL) regarding some rules mentioned and about wanting them reviewed due to being unrealistic given the age of the young people. This was discussed with the centre manager as an area for review and improvement to ensure equality across all the young people's care relative to their age and development.

The young people contacted their family by phone. There was contact between one parent and the social work department where the parent was able to dial in for the young person's CICR. Inspectors saw during the file review that there was regular contact with the social workers, GAL's and social care workers regarding the care of the young people.

Standard 1.4 Each child has access to information, provided in an accessible format that takes account of their communication needs.

The two young people that spoke with inspectors stated they had received information in a booklet form when they arrived at the centre. This was translated into their own native language for them to understand. The young people stated during interviews that staff spoke with them regularly to inform them of any other relevant information they may need to know about the area, their education and additional supports, should they require them. Part of the booklet explained to the young people what to expect from living in the centre and who they could talk to if they needed any further clarity.

The staff informed inspectors during interview that they informed the young people about EPIC but that there hadn't been an advocate out to meet with them yet. The young people that spoke with inspectors stated they were not aware of EPIC or the service they provided. Inspectors recommend that information about EPIC and the ombudsman for children is made available to young people.

Given the circumstances in how the young people came into care, there was little history known about them or their families. As time passed and relationships grew, the young people shared some of their personal information, some of which was traumatic. The staff responded in seeking out relevant supports for the young people if they wished to engage in them. Appointments with the GP or other support services was facilitated to help and support the young people with any trauma they had endured. Inspectors did find that the staff team need to be made aware that young people's confidential information regarding child protection concerns should only be shared on a need-to-know basis in the best interests of the child/young person.

There was information about the National Standards in the booklet provided to the young people.

As part of the inspection, there were numerous records belonging to the young people reviewed. Inspectors found there were deficits in the recording of information, identifying child protection concerns, reporting child protection concerns and the standard of report writing required improvement. For example, the key working completed with the young people was documented as general conversations rather than addressing specific goals. There were child protection disclosures made by the young people around their experiences prior to coming to Ireland and about their journey here. These disclosures were not identified as child protection concerns and were not reported through the portal on a child protection welfare report form (CPWRF). This must be reviewed by the designated liaison person (DLP) and then review the responsibilities of a mandated person with the team.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 11** **Regulation 12** **Regulation 17**
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 1.1** **Standard 1.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must ensure the young people receive feedback on any issues they raise at young people's meetings, that there are records kept about the feedback and their response.
- The centre manager must ensure that curfews and interventions undertaken are equal, realistic and reasonable for all young people.
- The centre manager must ensure that any disclosures made by young people remain confidential and are only shared with relevant people with the young person's knowledge.
- The centre manager must ensure that when disclosures are made by the young people that they are identified and reported as required on a CPWRF.

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 there were not sufficient management arrangements in place to provide governance and oversight to the centre. There was a new centre manager

appointed in February 2024. There had been an induction completed with the new manager by the previous manager of the centre over a few weeks, however the purpose and function of the centre had changed in November 2023 to now providing care to young people seeking international protection. The centre's registered capacity had also increased to six. There was one team leader who supported the manager, however, was only on shift at three days per week and was supporting the manager with the oversight of the paperwork. This deficit was highlighted by the centre manager during interview and was brought to the governance meeting for discussion. In the sample of governance meetings reviewed, inspectors did not see this discussed however, there were plans named to inspectors from the registered provider for further resources to be allocated to the centre. It was not known when this would happen.

Inspectors interviewed the registered provider who explained that they visit the centre to check in and see how the property is. The registered provider stated they do not review the young people's files or complete supervision with the centre manager. There were externals auditors that reviewed the files and an external supervisor had been organised for the centre manager for supervision. The register provider stated they attended the governance meetings weekly and that informed them of what was happening in the centre. The inspectors did not see any evidence of anyone from the governance team having oversight of how the centre was being run on a day-to-day basis, of how the care was provided to the young people or oversight of the young people's documentation.

There was one audit forwarded to inspectors from February 2024 completed by external consultants, which reviewed theme 3 and theme 8 of the National Standards for Children's Residential Centres HIQA 2018. There were recommendations as part of this audit, which inspectors did not see actioned. Inspectors found the audit did not capture staff's knowledge and understanding of their responsibilities as mandated people to report concerns and inspectors found that staff had not been reporting concerns in line with their mandated role. There were recommendations for training around mandated person, human trafficking and child sexual exploitation. This was not evident on the training logs forwarded to inspectors. It was also highlighted in the audit that the centre was not complaint in their staffing in line with ACIMS regulatory notice memo. On receipt of the staffing information form, it identified that there was the manager and six full-time staff currently, which was below the required minimum for staffing numbers in the centre. The daily logbooks were reviewed by the inspectors and found eighteen different names of staff recorded as working in the centre in the last two months.

The centre manager during interview discussed the team and how they were eager to learn and develop with ongoing training planned for the team. Inspectors found that the care and dedication from the team was evident to the young people's needs, however due to the number of new staff, the team lacked experienced members to help further develop the team and the systems within the organisation. The systems in place were not robust or consistent and support was required from the senior management team to the newly appointed centre manager in managing the governance oversight.

During interviews with staff, they stated the manager was supportive to them, they were aware of their responsibilities. The staff were aware of the structures within the centre and who they could speak to if they had any issues or concerns. They did not know who the designated liaison person (DLP) was and this needs to be addressed.

The inspectors were informed there was a service level agreement (SLA) in place with Tusla and that the organisation provided updates about the young people as part of its compliance with the SLA. The centre manager was identified as the person in charge.

Policies and procedures had been forwarded to the inspectors and were dated October 2023 with a further update that was due to occur in December 2023 to reflect the changes to theme two of the National Standards regarding the change of purpose and function in the centre. Inspectors could not see evidence of any updates made or any reference in the polices and procedures to reflect that the centre now provided care to separated children seeking international protection. Inspectors were informed during interview with the centre manager that some policies were still being reviewed but were not forwarded to the inspectors at this period. The policies and procedures must reflect and be relevant to the new purpose and function of the centre. Inspectors found areas around the admissions process were not followed in line with policy regarding securing appropriate information to have on file such as care orders. The inspectors recommend an admissions checklist to ensure the centre has all the relevant documentation for the young people on file and can track that they have provided relevant information to the young people.

The risk management framework included individual risk assessments for young people, safety plans if required and a centre risk register. There was no evidence of how the risks were being managed, if they continued to be a risk, or if they were being reviewed. These risk management structures were insufficient and must be reviewed. There was individual crisis support plans (ICSPs) and absent management plans

(AMPs) in place for the young people. These AMPs were inconsistent and some of the interventions in place could not be accounted for when inspectors queried them with the centre manager. The AMP's did not give clear guidance around what staff should do if a young person was missing from care. These processes required review.

The-management structure consisted of the centre manager, director of governance and the registered provider. Both the centre manager and the registered provider deemed this satisfactory, however inspectors found the operation of it is not. Given the findings above with a number of deficits noted, it showed that the governance oversight was not sufficient in the centre. The team leader was identified as the person who would act up during periods when the manager was absent. However, the team leader only covered three days of the week when the centre manager was absent. There must be sufficient alternative arrangements in place when the person in charge is absent.

The inspectors were provided with a list of delegated tasks to staff that consisted of for example, the health and safety officer, medication officer, first aid officer and fire officer.

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

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- The registered provider must ensure that the governance systems in place identify and respond appropriately to the day to day running of the centre.
- The registered provider must ensure that there is oversight from the governance team to address the actions that had been identified from the audit undertaken in February 2024.
- The centre manager must ensure the staff are aware of who the DLP is.

- The registered provider must ensure that the policies and procedures reflect and are relevant to the new purpose and function of the centre.
- The centre manager with the governance team must ensure there is a robust risk management framework in place and that it is reviewed to ensure its effectiveness.
- The registered provider must ensure there is sufficient alternative arrangements in place when the person in charge is absent.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure the young people receive feedback on any issues they raise at young people's meetings, that there are records kept about the feedback and their response.	The Centre Manager (CM) has developed and will oversee a forum where the CM, or alternatively the Team Leader in-situ, will meet with the young people to provide feedback on the issues they have raised. In place.	The record of the forum meeting shall accurately reflect the topics discussed, the issues raised in feedback, and the action taken on foot of the feedback received. The record will be monitored for periodic review by the PGM
	The centre manager must ensure that curfews and interventions undertaken are equal, realistic and reasonable for all young people.	The CM has met with each young person to discuss their curfew times. The curfew for each young person is developed in collaboration with the SWD where it is agreed and signed off by the allocated SW.	IAMPs and updated IAMPs will be sent monthly to the allocated social worker for their records and sign off to be emailed back to the centre for placing on the young person's file.
	The centre manager must ensure that any disclosures made by young people remain confidential and are only shared with relevant people with the young person's knowledge.	The CM has, in several team meetings, emphasised to staff the confidentiality of disclosures by young persons and how this information is only shared with the relevant people and professionals with the young person's knowledge (July 2024)	Staff are reminded in supervision and at team meetings of their responsibility as part of an overarching discussion of child safeguarding. The induction process for new staff identifies clear steps in dealing with and managing disclosures made by young people.
	The centre manager must ensure that	The CM ensures that each member of staff	Each member of staff is trained and

	when disclosures are made by the young people that they are identified and reported as required on a CPWRF.	follows the protocol in meeting their obligation of CPWRF disclosures through submissions via the Tusla portal to the relevant SWD. August 2024	certified in mandated person's and Children First training as to the steps required to report disclosures as a CPWRF.
5	The registered provider must ensure that the governance systems in place identify and respond appropriately to the day to day running of the centre.	The registered provider will expand the membership of the Proprietor's Governance Meeting (PGM) to include a professional social worker (PSW) to enhance the governance and day to day running of the centre. 1 September 2024.	The assigned resource will hold bi-weekly meetings with the CM and within the existing governance and line management structure respond appropriately to the day to day running of the centre.
	The registered provider must ensure that there is oversight from the governance team to address the actions that had been identified from the audit undertaken in February 2024.	The PGM is overseeing the implementation of actions arising from the February 24 Internal Audit. Ongoing, for completion by 30 August 2024.	The internal audit will take place every six months save in the event of an external inspection when it will be six months after receipt of the inspection report.
	The centre manager must ensure the staff are aware of who the DLP is.	The PGM has appointed the CM as the DLP; Team Leaders have been informed and staff have been briefed.	At induction new staff will be briefed on the role and function of the identified DLP.
	The registered provider must ensure that the policies and procedures reflect and are relevant to the new purpose and function of the centre.	The PGM adopted (18th June) a revised purpose and function that reflects the care of SCSIP. Policies and Procedures will be reviewed in line with the new purpose and	Policies and Procedures will be aligned with current standards and with the statement of purpose and function above

		function. For completion by 31 October 2024	
	The centre manager with the governance team must ensure there is a robust risk management framework in place and that it is reviewed to ensure its effectiveness.	The CM reviewed and the PGM adopted a high-level policy towards embedding Risk Management in the service. The CM will implement a new risk management framework in line with applicable HIQA national standards for completion and review by 1 October 2024.	The PGM will, in conjunction with the CM and with recourse to its additional professional capacity, actively assess the robustness of Risk Management in the centre with a view to ensuring its ongoing effectiveness in safeguarding children and young people.
	The registered provider must ensure there is sufficient alternative arrangements in place when the person in charge is absent.	Vacancies in the management team (CM and two TLs) have been filled and the team strengthened. The Centre is now operating with the CM and 3 Team Leaders. (July 2024) The CM has an on-call system in place. The centre is represented six days a week with a management structure of the CM and / or an on-duty TL.	The registered provider will ensure that vacancies are filled as they are foreseen, and that the strength of the management team is maintained. The registered provider will, through the PGM and CM ensure that the alternative arrangements in place are sufficient when the person in charge is absent.