An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 086

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Streetline CLG**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**22nd, 23rd and 28th of November 2023**
Registration Status:	**Registered with conditions attached from 31st of May 2023 to the 31st of May 2026**
Inspection Team:	**Eileen Woods** **Catherine Hanly** **Lorraine Egan**
Date Report Issued:	**18th April 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 31st of May 2002. At the time of this inspection the centre was in its eight registration and was in year one of the cycle. The centre was registered without attached conditions from the 31st of May 2023 to the 31st of May 2026.

The centre was registered as a multi-occupancy service for up to a maximum of four young people on a medium to long term basis aged 13 to 17 years old. The model of care was psychodynamic, humanistic and trauma informed, creating a safe and secure environment with everyday reparative opportunities for growth and development. The staff team were guided and briefed on how to implement the model to enhance their understanding of the young people. There were two young people living in the centre at the time the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.5
4: Health, Wellbeing and Development	4.3
6: Responsive Workforce	6.4

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 19th of December 2023. 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 11th of January 2024. This was not deemed to satisfactorily respond to the issues for action. The lead inspector requested evidence of items addressed to date, further detail was requested regarding persons identified for ongoing work to ensure improvements and a date was to be agreed for a second review of the staff personnel files to ensure that they had come into compliance. The centre manager responded, with attached evidence and an updated CAPA on the 18th of January 2024, with a further updated version provided on the 31st of January 2024.

A date was set for the 2nd of February 2024 for the personnel and training files to be reviewed. The personnel files and training certificates were reviewed and did not meet the required standard with regard to training and there was evidence of noncompliance with best practice in vetting procedures. A regulatory compliance meeting was held with the management and chair of the board of this voluntary body and the ACIMS regional inspector manager and the head of inspection on the 20th of February 2024.

The findings of this report and assessment of the submitted CAPA and additional information deem the centre to be continuing to operate in adherence with regulatory frameworks however adherence to named standards, completion of training and implementation of the CAPA in response to this inspection requires ongoing attention and work. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 086 with attached conditions from the 31st of May 2023 to the 31st of May 2026 pursuant to Part VIII, Article 61, (6) (a) (i) of the Child Care Act 1991.
The condition being:
Evidence must be submitted to the Alternative Care Inspection and Monitoring Service that:

1. All staff have complete certified training in fire safety, evacuation and other procedures to be followed in the event of a fire.
2. All staff have completed certified training in first aid.

3. For staff who have lived in a state other than Ireland for a period of longer than 6 consecutive months, vetting information in respect of the person must be obtained from the police authorities in that state.
4. Evidence that the internal quality audit procedures had commenced.

The condition being that all actions in point 1 to 4 above identified are fully implemented.

This condition attached to the registration will be reviewed on or before the 30th of June 2024.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 7: Staffing
Regulation 9: Access Arrangements
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.5 Each child develops and maintains positive attachments and links with family, the community and other significant people in their lives.

Inspectors spoke with family, social workers, staff and management during this inspection. The two young people did not take up the option to meet inspectors or to complete a questionnaire on this occasion. The views of the young people were therefore those that were recorded by staff, relayed by their social workers and family. The family that inspectors spoke with were very happy with their experience to date with the staff team, particularly in how they communicated with them and listened to them. They stated that although there were safety concerns related to the location, that the centre had been good for the young person, they found that the team were clear about the rules, the supports and the expectations for young people. The two social workers were also satisfied with how the team engaged with family and navigated family networks with the young peoples wishes and views to the forefront.

Inspectors could see the views of the young people regarding family contact recorded on the placement plans and it was clear that the team were experienced at guiding, advising and engaging with extended family. They put practical and caring actions in place that recognised the lasting value of connection to family and how to develop those connections to healthier and more stable foundations. Family members were invited to the centre, where they didn't wish to visit or couldn't, the staff supported the young people with arrangements, travel, gifts if needed and special occasions were celebrated.

Whilst the placement plans reflected family and education to a better extent inspectors found that overall the placement plans required attention to ensure that they become a rounded reflection of the young people's aims, goals and needs. Inspectors also found that there were limited records of key working related to every

area including family and limited recording of one to one work maintained, these must be improved. The team meetings were held weekly and there were minimal notes maintained of those meetings resulting in an overall absence of information aside from what could be understood from the outcomes, from the interviews and daily logs. Standards in record keeping and placement planning had not been audited so there had been an absence of recorded feedback to staff around expected standards in record keeping. The areas of strength had become more defined which were education and family work and inspectors found a strong sense of worry and concern about behaviours being displayed and the teams ability or suitability to manage these behaviours.

A copy of the young people's booklet was provided to inspectors and the version provided was out of date as it referred to family contact in the context of the earlier stages of the pandemic and therefore was no longer applicable. An up-to-date young people's booklet must be put in place that accurately represents how family, friends, hobbies and community are promoted and supported. The young people must be offered the opportunity to guide the development of the booklet and be given an updated copy once it is available.

The young people could bring in friends to the centre, this had been ceased for a period of time and this was not considered by the staff team as a restrictive practice which it is. Inspectors found that where such an action is taken that it should be recorded as a restrictive practice and tracked through to its removal.

The young people had explored a number of sports and interests with staff and had maintained a core interest each in boxing and attending the gym. These had been supported again by staff through their community connections and links to other voluntary bodies to the benefit of the young people being opened up to new opportunities to achieve and to mix in positive situations. The young people had access to the internet and a laptop at the centre, they had phone credit bought monthly by the team. There were records of birthdays, anniversaries and special occasions being acknowledged and celebrated.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 7** **Regulation 9** **Regulation 17**
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 1.5**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required

- The centre management must ensure that an up to date young people's booklet is created that accurately represents how family, friends, hobbies and community are promoted and supported. The young people must be invited to contribute to it and be given a copy of it once updated.
- The centre management must ensure where a house policy is changed that it must be recorded as a restrictive practice and tracked until it can be removed.
- The centre management must review the placement plan content and key work recording to ensure that improvements are made and that levels of detail are consistently improved through a focused development plan.

Theme 4: Health, Wellbeing and Development

Standard 4.3 Each child is provided with educational and training opportunities to maximise their individual strengths and abilities.

The inspectors found that this was a centre rooted in its local community and local area for many years. It was connected to other voluntary bodies and city education and training centres and institutions with whom they had fostered good mutual working relationships that benefited young people. This was in line with the centres ethos and inspectors could see the evidence of where it played a central role in the work completed by the team.

There was written and verbal evidence of the young people's wishes regarding their education and training hopes being explored with them. Where a young person was

reluctant to engage in this the team made plans with the social worker and held regular meetings, such as strategy and professional's meetings to help clarify and guide plans. For one young person there was no evidence provided by Tusla of their childhood education outside of Ireland, the social worker explained that this information had been difficult to gather and remains an ongoing issue. The centre had advocated and continued to advocate for a private educational psychological assessment to be progressed by the social work department. There was evidence on file of the centre management escalating actions around this to senior social work management to emphasis the urgent need for this to take place. The centre management had utilised other services including a clinical professional to assist on advising and meeting with young people to help best support them individually in the interim. The social worker stated that they had not had an update on the funding approval and stated that it was being followed up internally by the social work team.

Both young people had schools and courses sourced for them, this happened without delay either before or at the point of admission. Inspectors found it notable that where a young person encountered problems that the team quickly ascertained the information about what had gone wrong and why and looked at whether, with the young person, that this could be repaired. Where it couldn't be repaired there was rapid action to secure another course or school after taking the young person's feedback, their actions and the education setting feedback into account. The team weighted the young people's strengths and abilities with the known information available at that time in this process.

There were meetings or phone calls with school personnel or course heads/co-ordinators. The centre management had engaged with the education and welfare office and an education specialist from Tusla who they met with regularly in support of the young people involved. The young people had been supported into a number of different courses or schools and both were maintaining a place at the time of the inspection. Young people had attended additional short courses such as a barista course and one had a number of part time jobs at various times. They had been supported to explore work skills, interviews, applying for jobs and updating their CV. There was further evidence of looking to post eighteen and preparation for the adult work place and the skills that would be beneficial for this, for example a social worker had obtained funding for driving lessons for a young person.

The centre provided a desk in each bedroom and there was a sitting room and kitchen downstairs where staff assisted young people if they wished. The staff and management had a short monthly file audit checklist that represented actions relating to education well.

Compliance with standards	
Practices met the required standard	**Standard 4.3**
Practices met the required standard in some respects only	**Not all areas under this standard were assessed**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required

- None identified

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

Inspectors requested access to the personnel files and the training files for this inspection. Upon examination it was found that there were significant deficits in both. Following a review of an initial sample inspectors found that there were poorly presented and that they were not in compliance with the Guidance to Registered Providers Part VIII Child Care Act 1991 Staff Vetting Requirements, ACIMS, 2023. Inspectors supplied initial findings on deficits found and inspectors informed the centre management of the requirement to obtain overseas police vetting and other outstanding items as a matter of priority.

The personnel files reviewed did not contain evidence of the completion of mandatory training for all staff. A training schedule and additional digital files did not provide evidence of completion of the required mandatory training either, no evidence was seen for practical fire safety training having been completed for example. Whilst it became clear that training in the chosen model of behaviour management, First Aid and Children First online had been either scheduled, completed or followed up, this could not be verified by inspectors as consistently the case for all members of the team. Each person on the team must have proof on file, available for audit and inspection, that contains evidence of their mandatory training,

any additional complementary training and if not present then an explanation for their absence or delay must be clearly recorded.
This centre did not have an auditing mechanism in order to assure themselves as to the quality and compliance of the personnel and training files and this is required. The creation of the personnel and training files were a combined process between a governance manager and the social care management team and they had not co-ordinated to ensure the files were to a minimum standard. The management outlined structural issues relating to office space, access to a scanner and printer as being key factors in the creating of the personnel and training records. They had reverted to relying on a screenshot of online Tusla provided training and not requiring all staff to download the available certificates for the digital training records.

A number of new staff and relief staff were employed on the basis of training completed in other companies or voluntary bodies, some of these certificates were available on the personnel files but not all. There was no requirement from centre management to complete dedicated training if it was deemed to have been recently completed elsewhere, for this to be the case then all relevant proof of that training must be followed up.

At the time of the inspection there had been delays in accessing refreshers and core training, through Tusla, for the approved method of management of challenging behaviours. There was evidence of this training being discussed and followed up at supervision sessions. There was no dedicated training in the centres model of care but the centre manager outlined that they had sourced upcoming training from suitable professionals in areas impacting young people, such as mental health awareness. The centre manager ensured that the model was supported through awareness of the statement of purpose and function and principles of care, through readings provided to the team, through discussion at team meetings and during supervision.

Inspectors found that the provision of supervision lacked consistency in its delivery so that the core team were not uniformly receiving supervision in line with the policy. As the key place where training and development, induction and support of the model of care takes place it must aim to be in accordance with said policy. Inspectors interviewed two staff members who stated that they had been advised on an ongoing basis regarding the model of care in practice and could give examples of a strengths based, early childhood trauma informed approach that prioritised education, family and community. They also noted additional complementary training and briefing

sessions conducted for the team, for example in drug awareness with more training upcoming in mental health awareness.
The staff were aware of the policy document and the policies had been updated in May 2023, knowledge of the policies relating to key working and placement planning required attention and team training must take place in these policies.

There was a brief policy for induction and a set format in place. Inspectors found limited recorded evidence on file of inductions being completed that were in line with the policy and format set out for the centre. There was evidence in supervision records of aspects of induction in particular the support of the model of care. The staff interviewed by inspectors described completing inductions including when they moved from a relief role to a full time role. The confirmed also that they had been rostered off in advance for any training that they had undertaken. The centre manager and the deputy manager were commencing a process of yearly appraisals and inspectors advised that they complete a training needs analysis as part of this.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
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	**Not all areas under this standard were assessed**
Practices did not meet the required standard	**Standard 6.4**

Actions required

- The centre management must put an audit mechanism in place and thereafter complete a full audit of the staff personnel files. An immediate plan must be put in place to address the deficits identified. The updated personnel and training files must be presented for inspection to the ACIMS by the end of January 2024.
- The registered proprietor and centre management must ensure that a record of all mandatory training completed is maintained.
- The centre management must ensure that the induction policy is implemented in a consistent manner for all staff, that the dedicated template is completed and filed to inform probations and ongoing planning for training and development.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre staff team must ensure that an up to date young people's booklet is created that accurately represents how family, friends, hobbies and community are promoted and supported. The young people must be invited to contribute to it and be given a copy of it once updated.	The young person's booklet has been discussed and reviewed at Team Meetings with staff team. Young people in the house have discussed it with staff over the previous weeks and they are working with staff currently to implement suggested changes with additional details on significant people for the young person, hobbies, community engagement etc. The young people's booklet will be updated with amendments and young people's contributions by 02/02/2024.	An annual review will be done by the centre management with the staff team and with young person's input to ensure young people's booklet remains up to date and adequately reflects the house. Social care manager and the deputy social care manager to be responsible for the annual review with input from young people and staff.
	The centre management must ensure where a house policy is changed as a sanction that it recorded as a restrictive practice and tracked until it can be removed.	The restrictive practice form has been reviewed at team meetings with staff. A discussion on the restrictive policy in the house was held as well in line with our model of care as the recommendations from ACIMS highlighted Dec 23 and Jan 24. The restrictive practice form is	All restrictive practices will be recorded in new restrictive practices book for each young person with relevant date, details, and timeframe. Restrictive practices will be reviewed at weekly team meetings as in line per restrictive practices policy.

		currently in the printers as of 15.01.2024 being incorporated into booklet form with columns for responsibility, the date a restrictive practice is recorded and should be removed. Restrictive practices will be discussed and overviewed as per event with SCM and/ or SDM. All restrictive practices were and will be reviewed and recorded at team meetings; effective immediately (10.01.2024). Restrictive practices will be discussed and overviewed as per event with SCM and/or DSCM. An addendum will be added to include "Young People informed/consulted, if a SW needs to be informed and date of removal of RP"	
	The centre management must review the placement plan content and key work recording to ensure that improvements are made and that levels of detail are consistently improved through a focused development plan.	The placement plan will be updated monthly or more frequently as required with more detailed content added in line with the model of care. This will be completed by SCW staff, keyworkers and the centre management. Placement Plans will be discussed at team meetings, effective immediately with full review on	Monthly review of placement plan at team meetings presented by keyworker and updated to reflect clinical discussion and ongoing process work with the young person and engaged parties. Highlighted at team meeting. Initial date planned for Placement plan overview at team meeting chaired by social care manager and deputy

		last team meeting of each month. Re-introduction of clinical practice report template with discussion at each team meetings to reflect more detailed clinical content, key working observations, understanding of young person and "what has changed" has been reintroduced. This is to be more process led and goal-oriented to ensure continuous improvement; effective immediately as of 03.01.2024.	social care manager 31.01.2024. A monthly audit of placement plan content and key-working content by centre management (SCM and DSCM check and external review if required by Governance manager) using file audit system has been implemented. The "Centre National Standards Audit V1 template" will continue to be worked on to ensure ongoing audit and the steps the centre is taking to ensure continuous improvement.
4	None identified.		
	The centre management must put an audit mechanism in place and thereafter complete a full audit of the staff personnel files. An immediate plan must be put in place to address the deficits identified. The updated personnel and training files must be presented for inspection to the ACIMS by the end of January 2024.	There has been a re-introduction of the personnel file audit system. A full audit of personnel files started in December 2023 and will be completed by 02/02/2024 with any deficits addressed. Once reviewed, the current staff personnel files will be considered audited (staff up to 31 Dec 2023). The only additions to 31 Dec 2023 files will be annual supervision / probation / appraisal schedules, sick	The centre management team personnel file audit system reintroduced with printing of physical copies of all information for the personnel file arranged in a cohesive linear manner. This will be completed by social care management team, HR manager, supported and overviewed by social care manager and the deputy social care manager for all personnel files. Using the personnel file

		notes/leaves, complaints/disciplinary, resignations and financial/holiday agreements. The latter will be reviewed with SCM and Governance Manager every month and discussion of same is included in the centre management (Governance Manager and SCM and/or DSCM) weekly meeting template.	audit system, a formal physical check of all required documentation will be carried out in person by SCM with Governance Manager each time a new staff member is hired (from 1 Jan 2024).
	The registered proprietor and centre management must ensure that a record of all mandatory training completed is maintained.	Since December 2023, the training folder (incorporating "Mandatory", "Centre-Mandatory" and other CPD) has been removed from each staff member's physical personnel file, and there is now one Training Folder Box in the staff room for all printed certs. The printed mandatory training certs are to match those on the individual staff digital training folder on the Staff Desktop. Training has already been given and will continue to be given in the individual Excel Training/CPD tracking audit system developed in December 2022, with each staff member having individual training excels tracking all CPD. The training	Training has been and to be given in the new year (early 2024 due to Christmas and New Year) in the Excel training System as required. Weekly audit by social care manager and deputy social care manager and monthly auditing by Governance manager on training desktop folder and corresponding physical copies for all staff. Physical and digital training folder/box containing digital and physical certs (if available) to be kept in main office for staff accessibility. The centre management team to keep training on team meeting agenda for all staff. Social care manager to liase with HSELand and Tusla for TCI training as

		folders (physical and digital) will be checked by social care management team weekly to ensure compliance and the digital file will be sent monthly for auditing by the Governance Manager; effective immediately. All staff currently up to date and/or booked into available limited places for TCI training Tusla Jan-March 2024. Training and the new system has been on the agenda and discussed at each team meeting with all staff to ensure all staff are up to date with training requirements. It is and will also continue to be part of individual staff supervision with the social care manager and the deputy social care manager.	required, and all staff are currently up to date.
	The centre management must ensure that the induction policy is implemented in a consistent manner for all staff, that the dedicated template is completed and filed to inform probations and ongoing planning for training and development.	The induction system has been modified so that induction is only deemed complete and to be filed by the governance manager in the physical personnel file once the new staff member and social care management have signed off on each section of the template including discussion of probation.	Induction Box to be kept in social-care Management office with removal of all policies. Induction Box should be empty if a staff member has been fully inducted and completed Induction document be held within the staff member's personal file. The social care manager and the deputy social care manager to inform the governance

		The social care manager and deputy social care manager to inform governance manager when a staff member has completed all relevant sections of induction and/ or if any HR issues and to ensure within the first month all of the Induction checklist for new staff is complete and filled in induction box. Effective immediately from 01.01.2024 Governance manager to check the mandatory training section of the training audit file. Effective immediately 10.01.2024	manager of competed induction sheet for staff file. End of probation date to be indicated in annual supervision schedule, the social care manager and the deputy social care manager inform the governance manager and accompanying note in personal file. The annual supervision schedule to be done up by January 31st each year and sent to the governance manager and kept in personnel file with the date changes tracked by social care management team in the individual supervision files and sent bi-annually from social care management to governance manager to inform probations.