An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 176

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Curam Nua**
Registered Capacity:	**Two young people**
Type of Inspection:	**Themed CAPA Review**
Date of inspection:	**17th January 2022**
Registration Status:	**Registered from 20th September 2020 to 20th September 2023**
Inspection Team:	**Ruth Coakley** **Janice Ryan**
Date Report Issued:	**28th April 2022**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in 2020. At the time of this inspection the centre was in its first registration and in year two of the cycle. The centre was inspected in September 2021 and following the findings of that inspection it was registered with an attached condition from the 20th September 2020 to 20th September 2023. That condition being:

- There must be no further admissions of a young person under 18 to this centre until the centre can provide evidence of the person in charge, that suitable care practices and operational policies are in place and the number, qualifications, experience, and availability of members of staff in the centre are adequate having regard to the number of children residing in the centre and the nature of their needs.

The centre was registered as a dual occupancy centre and provided medium term residential care for up to two children, single gender from age thirteen to seventeen years on admission. Their model of care was described as the provision of residential care for children using a '*blended theoretical and best practice approach*'. The model was underpinned by the theories and frameworks of a person-centred approach, attachment theory and attachment informed parenting, a resilience strengths-based approach and a trauma informed model of care. The engagement of children in outdoor pursuits was also a key component of the therapeutic programme of care in the centre. At the time of inspection there were no young people in residence.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation and visited the premises to review 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 21st of February 2022. 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 07th March 2022.

The findings of this report and assessment by the inspection service of the submitted action plan were used to determine the centre's compliance and adherence to the regulatory frameworks and standards in line with its registration. It was the determination of the Registration Committee that the centre has now met the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 5, Care Practices and Operational Policies or Article 7, Staffing.

As such it is the decision of the Child and Family Agency to register this centre, ID Number: 176 without attached conditions from the 20th September 2020 to the 20th September 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

At the time of inspection, there were no young people residing in the centre. The records reviewed for this inspection related to the placement of a young person recently discharged from the centre.

Since the last inspection, the centre had implemented an amended handover and daily logbook which supported the accurate recording and follow up of information. These records included information in relation to significant events, key working, placement planning and the day-to-day duties of the centre. The recording of definite actions had improved considerably as identified in the most recent inspection report. The inspectors found these updated records to be of a good standard with oversight and sign off being provided by the social care manager and the new quality assurance and governance officer. This will significantly aid the planning of care for young people in the coming months.

The last inspection report identified concerns in relation to the keyworker role as set out in policy. As a result, the centre had completed key worker training with all staff on the 09th November 2021. The inspectors found this presentation to staff to be of a good standard. This presentation was also utilised as part of the service's new induction programme. Management had implemented a daily keywork learning review which was incorporated into the daily handover log for factual accuracy and feedback. Keywork was also discussed in supervision and at team meetings. The inspectors found in interview with staff that they were clear with regards to the expectations and responsibilities of this role as set out in the centre's new policies and procedures document.

On review of the centre's significant event log the inspectors found that there had been two incidents recorded for one young person in early December. Inspectors reviewed centre records and found that improvements had been made with regards to how incidents were recorded and reviewed in the centre. They found discussion at staff team meetings and through supervision of incidents. The recording of decisions,

actions and follow up had improved. Senior management meetings included the significant event review of incidents, but no incidents had been reviewed to date.

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

Compliance with standards	
Practices met the required standard	**Standard 2.2**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed.**
Practices did not meet the required standard	**Not all standards under this theme were assessed.**

Actions required

- None

Regulation 5: Care Practice s 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 service had appointed a new social care manager on the 02nd November 2021, a new deputy social care manager and quality assurance and governance officer on the 10th January 2022. There was a revised organisational structure in place which comprised of the company directors, directors, senior management team and a small advisory board who provided support to the director.

The internal management structure of the centre comprised of a social care manager, deputy manager, quality assurance and governance officer, social care leaders and social care staff. Three staff were assigned as social care leaders and one staff member had a dual role as a social care worker and to support the quality assurance governance officer. Issues in respect of this arrangement are discussed further in this

report. The social care manager confirmed that clearly defined duties and responsibility for staff in management positions would be defined over the coming weeks.

The service had completed a full review of existing policies and procedures as identified from the previous two inspections. The inspectors reviewed the service's Leadership and Management Policy and found that it was clear and set down the required standard for the centre. Staff informed inspectors that the service director was very supportive and visited the centre and met with staff and young people. The inspectors found evidence of onsite visits by the director however, oversight of centre records was not evident.

The inspectors found that the service had not fully implemented an internal audit system for the review of the service. In discussion with the director and quality assurance and governance officer they also advised that a system of audits had yet to be devised to support a systematic review of the day-to-day running of the centre.

Inspectors found that senior management meetings were in place and the service had engaged in two work group meetings to discuss the recent issues with the last inspection report and corrective and preventative action plan (CAPA). These meetings evidenced oversight and governance of the organisation and discussions took place in relation to recent CAPA reviews, new policies and procedures, staffing, rosters, and placement planning. The new centre manager provided the inspectors with an updated review of the centre's CAPA from the last inspection.

On examination of the two working group meetings in November which had been put in place to review the previous inspection's CAPA they evidenced that this task was allocated to the two centre managers in the service and the quality assurance and governance officer. The delegation of tasks to appropriate personnel had not been updated accordingly to reflect these changes.

The director stated that a staff member within the organisation had assumed the role of the governance and quality assurance officer. They had responsibility for the governance and oversight of both services within the. A staff member within each service was then allocated to support them in this role on a parttime basis whilst working as a social care worker.

The inspectors found the policy on Clinical Governance to be of a good standard. The centre was in the process of completing a three-week intensive induction programme

with all management and social care staff. This included comprehensive training and evaluation of the new policies and procedures. A training calendar was in place for the centre. This policy set out a clear auditing plan which was not implemented, and aspects of this policy was a work in progress.

Overall, the inspectors found that the new updated suite of written policies and procedures to guide staff practice and the care in the centre were improved, relevant and in line with best practice. However, the inspectors recommend that these policies are reviewed on a regular basis and are aligned with new and existing legislation and national policy to ensure their effectiveness in the service.

The inspectors reviewed the policy document checklist to support the review of policies and procedures in the centre and recommend that this is updated to include date of review, date of last review and a section to identify new legislation/regulations relevant since last review and is featured as part of the new audit system.

The service had introduced a comprehensive induction training programme for all staff members in January. The inspectors found that this training was intense and covered all themes from the National Standards for Children's Residential Centres, 2018 (HIQA) and were aligned to the new suite of policy and procedures. The inspectors found that individual themes from the national standards were also presented at the staff team meeting by an identified staff member and presentations were of good quality. Following this training all staff were required to complete an evaluation sheet to determine their awareness and understanding of these policies and standards. Staff members had completed the Tusla E-Learning module: Introduction to Children First, 2017.

Staff in interview had a clear understanding of their responsibilities in reporting concerns in line with Children's First: National Guidance for the Protection and Welfare of Children, 2017. They understood their role and responsibilities as a mandated person. As part of the centre's new induction programme staff had completed training on the centre's child safeguarding statement. However, inspectors found that in interview, one staff member's response with regards to safeguarding were inadequate.

The service had introduced a new contract for all staff members which included a six-month probationary period. On review of the centre's probationary policy, this stated that a review would take place at the three-month mark or earlier if required.

Supervision had recently commenced under the new management structure. The social care manager confirmed that they had responsibility for supervising the deputy manager and three social care leaders in the service. The deputy manager supervised the five social care workers. The new supervision template was being utilised and the inspectors' found evidence of discussions in relation to case management, reflective practice, significant event learning and training. The inspectors reviewed a supervision record between the proprietor and new centre manager and found it to be very thorough and incorporated the duties and responsibilities of running the service with a clear induction plan in place. In interview, the social care manager confirmed that the director would visit the centre two days per week to provide further support as part of their ongoing induction in the centre.

The inspectors reviewed a sample of staff supervisions. They noted that discussions in relation to the new induction training had taken place, placement planning and new contracts. The inspectors recommend that ongoing learning in relation to the national standards and subjects covered through the induction programme remain as part of the supervision process.

Team meetings were in operation in the service and were on a monthly basis prior to January 2022. The inspectors found evidence from discussion with staff and management that team meetings would take place on a fortnightly basis and was incorporated into the new staff roster. They found attendance was low at times prior to January however, with the implementation of mandatory attendance this should alleviate this issue. The inspectors reviewed these records and found improvements with regards to the recording of discussion and definite actions taken, however they found that actions arising from one meeting in December had not been actioned or signed off.

Staff and management had completed training in the centre's risk management framework as part of the three-week induction training. The inspectors found in interview that staff had good knowledge of the risk management framework and were clear how to implement this in practice. The corporate risk register had risks identified that were due to be reviewed in January 2022, however, this review had not taken place.

The inspectors found that there were only two significant events for the service since September. Due to the low number of incidents for this service they found review of these events through supervision and team meetings with oversight provided by the centre management. Inspectors recommend that the significant event review group

would benefit with input from a TCI trainer/clinician who has expertise in this field. This would then support best practice and ensure that patterns of behaviour and learning outcomes for staff and young people are identified. They noted that significant event review remains a standing agenda item on the senior management meeting template, but none have been reviewed to date.

The inspectors found that the centre had made improvements with regards to the leadership, oversight and governance of the service which is supported by the implementation of a new suite of policies and procedures and new centre management structure. However, governance systems need to be in place to monitor the service to ensure that delivery of care is safe and effective.

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

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

Actions required

- The registered provider must ensure that there are suitable oversight and governance systems in place to ensure the centre is operating in compliance with the regulations and the national standards
- The registered provider must ensure that fit for purpose audits take place to assess the compliance with legislation and national standards.
- The register provider must ensure that staff have the appropriate skills, experiences, and competencies for the post for which they are employed.
- The registered provider must ensure that all corporate and centre risks are identified and recorded on risk registers, that mitigation strategies are in place and that these risks are monitored and reviewed on an ongoing basis.
- The registered provider must ensure that the record of all tasks delegated to appropriately qualified staff members as well as a record of key decisions is reviewed and updated.

- The registered provider must review the Complaints Policy and Safe Practice and Alone Working 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.

Staff recruitment and retention was the responsibility of registered provider/director of care in the organisation. Inspectors found evidence of work force planning at senior management meetings with involved discussion around new staff contracts, rosters, induction, and recruitment.

A sample of personnel files reviewed by the inspectors found issues in respect of documentation that was held on file. The inspectors found that seven staff had new contracts in line with their job position one of which needed to be signed by the centre manager. Two staff members had no contracts on file and one staff member had an old contract on file in relation to a previous position. Three staff members had no references on file and inspectors were unable to ascertain whether these references were in line with the department of health circular on vetting and recruitment, 1994. Appropriate staff information was not held on staff personnel files and some files reviewed did not contain verification of qualifications as required.

Inspectors also found that staff that were employed in the service for a long period of time had received the generic contract and the inspectors recommend that these are reviewed to reflect the probationary period element not being required. The inspectors found that the personnel file audit that had been recently completed did not adequately address the required documentation which was missing from the files.

Upon application for registration in 2020 information was provided to the alternative care inspection and monitoring service outlining the staff complement. The centre was subsequently registered to operate with a centre manager, deputy social care manager, and eight social care staff all working 37.5 hours per week. The inspectors reviewed the staffing complement and found it was in line with registration application due to the recent recruitment of new staff members.

The centre had put in a clear system for the management of annual leave and time off to ensure that the roster was operating efficiently in the service. The service had a dedicated relief staff to cover annual or other types of leave. On review of the roster inspectors found evidence that the majority of cover was being provided by two relief staff members.

Inspectors found that one staff member who had recently been promoted to social care leader level did not hold the appropriate qualification for this position.
The inspectors found no evidence of unqualified staff that were not part of the social care complement working in the centre. There was a formalised procedure for on-call arrangements at evenings and weekends. On sampling the centre records the inspectors found no evidence of calls made to the person on call or the advice or direction given however, they noted that the roster clearly recorded who was on call for each day.

The centre had updated the handover log, daily log and had put in place a new sign in and out book which accurately recorded who was working in the centre and attended handover meetings. The inspectors found these logs to be of good quality, but improvement is required with regards to the sign in and sign out book.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed.**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed.**

Actions required

- The registered provider must ensure that personnel files are reviewed to ensure all files contains required documentation.
- The registered provider must ensure that appropriate references are in place for all staff and that all qualifications are verified.

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 there are suitable oversight and governance systems in place to ensure the centre is operating in compliance with the regulations and the national standards	A new centre manager has been appointed and began the role on 02.11.21. Monthly Supervision for Centre Manager ongoing. Quality Assurance and Governance Officer appointed on the 01.11.21 and a part-time governance support in-house officer are currently fulfilling the role completing relevant audits. Theme 1,2 and 5 to be completed and forwarded to ACIMS by end of March 2022, April 2022, and May 2022 respectively. Monthly Management Meetings ongoing. These roles will initially focus on	The Senior Management team's role includes oversight and governance of all the Organisations services and oversees and governs all policy documents. All policy documents will be reviewed at least every 6 months (earlier if necessary/relevant). New format of and recording systems have been devised for Management Meetings. These will evidence oversight and governance within the organisation. The Bi-Annual Review of Policies and Procedures Calendar will be included on the Centre's National Standards for Children's Residential Centres, 2018 (HIQA) Compliance Audit, which will be completed by the Quality Assurance and Governance Officer. Quality Assurance

	The registered provider must ensure that fit for purpose audits take place to assess the compliance with legislation and national standards.	completing an evaluation of inspection findings and compliance with the National Standards. The organisation has appointed a Quality Assurance and Governance Officer on the 01.11.21. The key responsibility of this role will be implementation of existing audits templates. The Quality Assurance and Governance Officer was appointed within the organisation on the 01.11.21. A part-time governance support in-house officer has also been appointed. The Quality Assurance and Governance Officer has been attending monthly management team meetings and has been a part of the policy review process.	and Governance Officer will complete the National Standards Audit for Children's Residential Centres, 2018 (HIQA). The Director of Services will review the Centre Audits in conjunction with the Quality Assurance and Governance Officer on a monthly basis moving forward. Regular audits completed by Governance officer will ensure compliance with legislation and National Standards. Ongoing staff training will support the implementation and competition of Audits.

		Governance Audit templates have been devised and are currently being implemented across the organisation. All staff have completed 5-day training modules on all standards.	
	The register provider must ensure that staff have the appropriate skills, experiences, and competencies for the post for which they are employed.	The Centre Management Team has been restructured. A new centre manager has been appointed (Start date, 02.11.21) with the relevant experience as outlined in memo February 2020. A new Deputy Manager was appointed on the 10.01.2022 who has the appropriate skills, experience, and competencies for the post. Within the Organisation there is one	Criteria for all positions within the organisation have been included in job descriptions. A recruitment checklist is currently in development in association with the organisations HR support team. The checklist will be utilised during the interview process to ensure compliance with the National Standards. Staff member appointed in supporting Quality Assurance and Governance Officer

		appointed Quality Assurance and governance Officer responsible for audits. Each centre has one supporting staff member in relation to inhouse quality assurance and governance audits, however; they remain within the role of a social care worker. This role will be to fulfil the recommendations of the Quality Assurance and Governance Officer and complete relevant audits / templates.	with inhouse monthly audits understands their role within the organisation remains as a social care worker. The role of inhouse governance is to audit files and support colleagues with identifying areas for improvement within their recording and report writing. This will be reviewed / monitored in monthly supervision. Management to review and encourage newly appointed social care leader to explore all options of signing up to the Social Care degree and receiving relevant qualification.

	The registered provider must ensure that all corporate and centre risks are identified and recorded on risk registers, that mitigation strategies are in place and that these risks are monitored and reviewed on an ongoing basis.	The organisations Corporate Risk Register will be reviewed bi-monthly by the Senior Management Team effective immediately. Corporate Risk Register provides evidence that corporate and centre risks are recorded on registers, mitigation strategies are in place, and that risks are monitored on an on-going basis.	This systemic process has been added to the standing agenda on the Senior Management team Meetings.
	The registered provider must ensure that the record of all tasks delegated to appropriately qualified staff members as well as a record of key decisions is reviewed and updated.	The organisations Delegation Record structure has been amended and updated to include a record of key decisions made in relation to delegated duties in line with the National Standards requirements. In a similar vein, a Delegation of Responsibility Log has been adapted to include same which will be appropriately stored in the Individual staff members Supervision File. A delegation log has been established between Centre Manager and Deputy Manager to identify responsibilities and roles.	The Organisations Director of Services and the Monitoring and Inspection Service will be informed of any amendment or delegation of the manager's role. The Organisations Director of Services will review and provide final approval, or otherwise, of any extended period of time (more than one month) whereby the centre manager delegates any or all of their duties to an appropriately qualified member of staff.

	The registered provider must review the Complaints Policy and Safe Practice and Alone Working Policy.	The centre furthermore has a delegation record logbook of all delegated tasks to social care staff. The registered provider has reviewed the Complaints policy (Section 1, pg23) and Safe Practice and Alone Working Policy (section 3, pg141) 2022 and updated the Policies and Procedures accordingly.	Senior management and governance officer review of policies and procedures with staff every 6 months (earlier if necessary/relevant).
6	The registered provider must ensure that personnel files are reviewed to ensure all files contains required documentation. The registered provider must ensure that appropriate references are in place for all staff and that all qualifications are verified.	All Personnel files have been reviewed and updated to contain required documentation. Updated References are now secured in staff personnel files and can be accessed in the office.	Staff files will be monitored monthly by centre management and the Quality Assurance and Governance officer when completing audits. Quality Assurance and Governance officer completing audit in March 2022. The organisations Application forms have been adapted to outline the appropriate requirement in terms of references.