An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 200

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Misty Croft**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced**
Date of inspection:	**05th, 06th and 07th April 2022**
Registration Status:	**Registered from the 04th November 2021 to 04th November 2024**
Inspection Team:	**Linda McGuinness** **Joanne Cogley**
Date Report Issued:	**16th May 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 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 in November 2021. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from 04th of November 2021 to 04th November 2024.

The centre was registered to provide multi occupancy emergency, respite, short and medium-term care for up to six young people. It was dedicated to the provision of placements for young people entering the country as separated children seeking asylum. Referrals were accepted from Tulsa's social work team for separated children seeking asylum and the out of hours' social work department. The model of care was underpinned by Maslow's hierarchy of needs and the purpose was to meet the primary, individualised needs of young people through a young-person-centred approach with the aim of successful integration. It was described as needs led, child centred care with a focus on care, health, integration, education, and independence. 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
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews 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 22nd April 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 5th May 2022. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 200 without attached conditions from 04th of November 2021 to 04th of November 2024 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 wellbeing and personal development.

At the time of inspection there were six young people residing in the centre. One young person was recently admitted and a care plan review was scheduled. The other five young people had an up-to-date care plans on file following statutory review meetings upon admission to the centre. All were encouraged to attend their statutory review meetings and there was evidence that the centre worked closely with the supervising social work departments to implement the stated goals of the care plans.

Each young person had a placement plan on file that was aligned to the needs and tasks set in the care plan. There was evidence that young people were consulted and that their voice was represented through placement planning and through the complaints process if required. They were regularly supported through key working to set individual attainable goals. Placement plans were prepared by keyworkers, were regularly reviewed and included a progress report. Inspectors found that while placement plans covered all areas of need, they were in the first instance a narrative of the current situation and detail of work undertaken since the last review of the document. Tasks to meet identified needs were set, but these were a small part at the end of the plan. Three plans were dated March 2022 and two were February 2022. None were forward planning and dated April 2022, the month of this inspection and this must be addressed as a matter of priority. Placement plans must be drafted in advance to focus on goals, areas of need and specific tasks to meet identified needs.

The centre manager had oversight of planning and there was a system of keywork supervision in place whereby the social care leader provided guidance, support, and direction in respect of placement planning. Inspectors found that planned, comprehensive key working took place to support young people that included integrating them into the local community, online safety, sex education and healthy relationships, bullying and self-care amongst others. Inspectors noted that some aspects of ordinary day to day interactions were specified as individual work, and this was unnecessary. Staff confirmed that placement planning was discussed in staff

supervision and team meetings although these could be more detailed rather than completing a tick box to indicate completion. Due to the nature of this service young people's families were generally not involved in planning but contact with families and other important people in young people's lives was facilitated where possible.

The centre had regular contact with several external support services who could provide specialist supports such as counselling, play therapy and other interventions required by young people. If there was undue delay or extensive waiting lists, the centre worked in collaboration with the social work department to source suitable alternatives.

Inspectors found that despite resource pressures in the social work department, there was evidence that they worked in partnership with the centre to meet goals and identify suitable onward plans for the young people. Social workers for all six young people were interviewed by inspectors. While they indicated that there was good communication between them and the centre to facilitate planning, they informed inspectors that that there was an issue following the cyber-attack in 2021 and that attachments sent by the centre could not be opened. They had asked that documents be posted however none of those interviewed had seen and approved placement plans due to a misunderstanding that the issue was resolved. The centre manager must ensure that placement plans, and all other relevant documents are sent to supervising social workers without delay. Social workers also noted that the team were somewhat inexperienced and contacted them unnecessarily about aspects of planning that could be resolved in the centre or that they had answered a query and it was made again by other staff. Thresholds and guidelines for communication should be discussed at team meetings and clarity provided.

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

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

Actions required

- The centre manager must ensure that placement plans are forward planning, drafted in advance to focus on goals, areas of need and specific tasks to meet identified needs.
- The centre manager must ensure that social workers receive prompt notification of all relevant documents and that there is clear guidance in respect of communication with the social work department.

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.

There were clearly defined governance arrangements and inspectors found that there was strong management and leadership within the centre to ensure authority, accountability, and oversight of service provision. The internal management structure was appropriate to the size and purpose and function of the centre.

The centre manager was qualified and experienced and held overall authority for the delivery of the service being provided to young people. They were present in the centre during office hours from Monday to Friday and reported to the director of service who in turn reported to the managing director. During inspection interviews staff members said they felt supported by the centre management and that external managers were accessible and available to them and that they visited the centre.

All supervising social workers who spoke to inspectors stated they were satisfied that the centre was well managed and that they worked in partnership to ensure positive outcomes for young people.

There was a policy on corporate and clinical governance. Oversight of the operation of the centre was provided by the director of service and managing director through management meetings, professional supervision, and daily contact with the service. Inspectors noted that managers met frequently to discuss areas such as staffing, risk,

Covid 19, and significant events. Also, an overarching meeting relating to all aspects of the service provision took place in January 2022.

The centre manager prepared monthly provider reports (MPR) which were sent to the managing director, director of service and the principle social worker for Tulsa's social work team for separated children (SCSA). This report included information relating to communications with social workers, staffing, training needs, staff supervision, health and safety, care and placement planning, complaints, and significant events amongst other items relating to daily operations. The manager also provided a detailed monthly report for internal management. There was an electronic system in place whereby senior managers could access all centre records. Their oversight and commentary was evident on young people's and centre records reviewed by inspectors.

The director of service was responsible for conducting audits across all centres in the organisation. Inspectors reviewed two audits that were completed since the centre was registered. One was an audit of the young people's files that included care plans risk assessments and safety plans. There was an action plan and evidence of follow up where deficits were highlighted. A second audit was completed in respect of staff timesheets. At the time of inspection, the system of auditing was not structured to assess centre compliance with National Standards for Children's Residential Centres, 2018 (HIQA) and relevant regulations. The director of service informed inspectors that this was a deficit they had highlighted themselves and a new system was being devised.

There was a service level agreement in place with the Child and Family Agency. An annual report detailing compliance with centre objectives was prepared and circulated to all stakeholders. A quarterly meeting was scheduled between the director of service and Tusla to review issues arising in the MPR.

All levels of management and staff had job descriptions appropriate to their positions and during interview described details of their specific roles and responsibilities.

Inspectors found that operational policies and procedures were aligned to the National Standards for Children's Residential Centres 2018, (HIQA). They covered the period September 2021 to September 2023, but they were also subject to review taking account of updates to regulations and national standards/policy. Staff induction covered policy and procedure review and there was some evidence that

policies were discussed at team meetings however inspectors found this was not always effectively recorded.

The policy and framework relating to risk assessment was understood by the staff team and they described how it worked in practice. The risk management framework relied upon the use of a risk matrix and review of the risk register evidenced that appropriate control measures were in place to mitigate against identified risks. The register was up to date and regularly monitored and reviewed and risks above a score of 12 were escalated to senior management. Social workers interviewed by inspectors were satisfied that staff were alert to issues of risk and that it was well managed in the centre. Inspectors found that risk was discussed in handover and team meetings and was regularly reviewed at risk specific management meetings.

Inspectors found that that the risks associated with the Covid-19 pandemic were well managed across the organisation. There was prompt and regular access to personal protective equipment, cleaning materials and sanitiser. Staff received training relating to Covid-19 during their induction. Policies and protocols were reviewed in line with guidance and advice from the National Public Health Emergency Team and government guidelines.

There were appropriate arrangements for the social care leader provide managerial cover if the manager was absent from the centre. A formal system was required to record the managerial duties delegated. There was a record where members of staff had specific 'officer' duties such as health and safety, fire safety, Covid-19 compliance, or key-working oversight. There was an organisational on- call system in place to support staff and to manage incidents and risks in the centre and staff reported that this worked well in practice. There was a record maintained of calls made and the direction and guidance provided.

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

Actions required

- The managing director must ensure that there is a system in place to effectively assess centre compliance with National Standards for Children's Residential Centres, 2018 (HIQA) and relevant regulations.
- The centre manager must ensure there is a formal record where the managerial duties are delegated to another appropriately qualified person.

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.

Inspectors found that the organisation had good systems in place to manage the workforce to deliver safe and effective care. Workforce planning was discussed at team meetings and senior management meetings.

The staff team had remained stable since the centre was first registered in November 2021. At the time of this inspection the staffing complement consisted of the social care manager, one social care leader, and eight social care workers. Inspectors found that this was sufficient for the number and needs of young people at the time of inspection.

Inspectors found that some staff were relatively inexperienced but that they generally had the necessary competencies to meet the needs of the young people currently in placement. There was evidence from review of staff supervision that professional development was a priority and that individual areas for development were identified.

Double cover was always provided. At the time of inspection two staff members worked a twenty-four-hour shift and slept overnight in the centre. There was 30 minutes protected time for handover meeting at the end of each shift. Extra day shifts were scheduled depending on individual needs and appointments scheduled for young people in the service. The staff team worked an eight-week rolling rota which included a 'float' week whereby staff were available to cover planned and

unplanned leave. Staff and management reported to inspectors that this worked well in practice.

There was a dedicated panel of relief staff for the organisation who were available to cover annual and all other types of leave. Staff and management acknowledged that during the current wave of Covid-19 that it had been sometimes difficult to cover unplanned leave and that on approximately eight occasions they had to use agency staff. There was evidence that this was discussed at management level and an organisational planning meeting solely related to staffing took place on 29/03/22. At the time of inspection interviews were completed for the recruitment of extra relief staff.

From a review of a sample of staff files inspectors found that some staff qualifications were not verified by the awarding body and written references were not dated.

Inspectors found that there was an emphasis on staff retention and maintaining a stable core team. During inspection interviews, staff highlighted positive areas of working for this organisation such as professional supervision and training, supportive management, and an employee assistance programme. Centre management informed inspectors that there were pay increments and that staff appraisals were to begin in May 2022.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

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

Actions required

- The managing director must ensure that there is adequate relief staff to cover planned and unplanned leave and avoid a reliance on agency staff.
- The managing director must ensure that all staff qualifications are verified and that references are dated.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that placement plans are forward planning, drafted in advance to focus on goals, areas of need and specific tasks to meet identified needs.	The placement plan template form will be reviewed and updated to allow for forward planning. This will include plans to focus on individual goals and identified needs. The time frame for this would be 8 weeks, This will allow for a working group to review the document and make the relevant changes, present the document to the Management team. Then implement document as a working document.	Review of placement plans to be planned and changes made to the template when required.
	The centre manager must ensure that social workers receive prompt notification of all relevant documents and that there is clear guidance in respect of communication with the social work department.	Due to the ongoing IT issues that the social work department are experiencing, all attachment documents will be sent by registered post to the Social Work Department. Social workers will be informed of all documents being sent and follow up phone calls will be made to raise any immediate risks. Information	Regular communication and record of documents sent to the social work department to be recorded and sent to individual social workers.

		workshops can be provided to the team to ensure that SCW are not contacting the SW department about processes or queries that they should already be aware of. Examples of the type of workshops could be based on the asylum process and social workers will be invited to talk about the process. Team meetings could also be used to update the team on certain topics and processes.	
5	The managing director must ensure that there is a system in place to effectively assess centre compliance with National Standards for Children's Residential Centres, 2018 (HIQA) and relevant regulations.	The Director of Services (DOS) will carry out audits, reform and review over the next 8 weeks to ensure that the centre is compliant with the National Standards for Children's Residential Centres. Audit templates will be used to ensure that audits are in line with all areas of the national standards. Quarterly audits will be carried out focusing on certain themes within the national standards along with varies monthly audits. It is hoped that over the year a complete audit relating to all themes will have been completed and if needed some revisited within the timeframe of a year. An eight-week	Regular audits to be completed by the DOS. Quarterly audits will be carried out in line with the national standards.

	The centre manager must ensure there is a formal record where the managerial duties are delegated to another appropriately qualified person	timescale is in place to implement the Audit templates. A delegation record will be kept in the unit to ensure that tasks are delegated to another qualified person in the absence of management. We are currently implementing a new IT system which allows for delegation of tasks in the absence of management. The IT system will be launched 06.05.22. Additions to the system will be added over the next number of weeks.	Delegation records to be completed before management goes on leave. Once the new IT system is fully functioning all delegation of tasks can be recorded here.
6	The managing director must ensure that there is adequate relief staff to cover planned and unplanned leave and avoid a reliance on agency staff.	Staff planning meetings and a recruitment process will be held to ensure that adequate cover is available for the unit. Currently vetting and reference checking three new additional relief staff for our panel. At present we have 11 relief Social Care Workers across the company and are hopefully adding an additional 3-4(dependent on vetting and reference check timeframes)	Staff planning meetings to be scheduled throughout the year at management meetings.

	The managing director must ensure that all staff qualifications are verified, and references are dated.	Social care manager and director of service will ensure that all qualifications and references are verified and dated on all documents. This audit will be carried out over the next 4 weeks.	Staff files to be audited and any outstanding issues to be addressed immediately. All new staff files and documentation will be verified and dated.