An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 242

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Ann's Children Care Ireland**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**18th, 19th & 24th September 2024**
Registration Status:	**Registered from 23rd of February 2024 to 23rd of February 2027**
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Date Report Issued:	**3rd December 2024**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 23rd of February 2024. 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 as a multi-occupancy service. It aimed to provide accommodation and care for four young people aged between thirteen and eighteen years. The centre aimed to support young people who had experienced trauma and adverse childhood experiences. The centre was currently undertaking training in the Welltree model of care. There were four 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
3: Safe Care and Support	3.2
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. Inspectors spoke with three young people during this inspection. 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 29th of October 2024. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 20th of November 2024. 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: 242 without attached conditions from the 23rd of February 2024 to the 23rd of February 2027 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.

This was an announced inspection and a first inspection for this new centre that opened in February 2024. The first young person was admitted to the centre in April, and it was at full capacity with four young people by the middle of June. Inspectors found that three of the four young people had up-to-date care plans on file. All young people had their child in care review (CICR), however there was one outstanding care plan yet to be received by the staff. Inspectors saw evidence of the staff requesting the relevant care plan from the social work department. Inspectors attempted to make contact with all relevant social workers, however only two participated in an interview with inspectors. The two social workers spoken to had positive feedback on the centre, the staff and the care their young people were receiving in that placement. They stated that the actions identified in the care plan and placement plans were being fulfilled and that they were well informed and updated by the team on the progress of the young people.

Each young person had a placement plan in their file. The organisation had recently adopted the Welltree model of care, and the staff were implementing the placement plans under the Welltree outcomes framework. The staff team were currently undertaking relevant training in relation to developing this model of care. Inspectors found that the placement plans were linked to the care plan actions, however it became apparent that some actions identified at professional meetings had not been implemented and added to the placement plan as new identified goals. The centre manager and the staff team must ensure that they incorporate any actions identified at professional meetings into the young people's placement plans given the fact that this is a live working document.

The young people were given opportunities to attend their CICR. One young person did attend their CICR. The other three young people who did not wish to attend had their voices captured through the CICR forms. Inspectors found that clear arrangements were not in place for informing young people about the outcomes of their CICR and recommend that there is a process in place as to who is responsible

for informing the young people of decisions made at the CICR. Parents were offered the opportunity to participate in the CICR's and this did occur where it was appropriate. The young people's social workers and their family members were informed of how the young people were progressing in their placements. This was undertaken through telephone calls, emails and sending relevant documentation to the social work department.

The young people were assigned key workers and part of this process involved linking with the young people to ensure the goals they wished to achieve were part of their placement plan. This was completed regularly, and the young people were aware of how they were achieving their goals. Action plans were attached to the placement plan which showed what work was outstanding and what had to be completed. Three of the young people that spoke with inspectors stated they were happy, safe, and well looked after in the centre. The young people spoke of arrangements in place to meet their families and their friends. One young person highlighted their issue around their school placement and about their use of a gaming console. Inspectors fed back this information to the acting centre manager and regional manager as part of the inspection process. They were aware of these issues but stated they would link with the young person again. The team reviewed placement plans at team meetings and used other opportunities such as handover and supervision to discuss further areas for development for each young person.

External supports were in place for some young people to support them with behaviors that challenged, mental health issues and social integration supports. There was follow up required for other young people in relation to funding and access to other assessments. Inspectors recommend that both the centre and the social work department work together to ensure these assessments and supports are put in place as soon as possible and that if further delays exist that an escalation process is used, if necessary, as some of the outstanding actions were from September 2023, prior to the young person being admitted to this centre in June 2024. Inspectors did not speak with this young person's social worker for further feedback.

During interviews inspectors were informed that for the most part, contacts with the social work department had been positive. Where issues did arise regarding communication this was escalated to the social work team leader. From a young person's questionnaire and from their CICR form inspectors saw that one young person was unhappy with communication and follow up from their social worker. The centre staff must support the young people and remind them they can access Tusla's Tell Us complaints process if they are unhappy with the current support they're

getting from their social workers. Inspectors asked staff during interview if this issue had been discussed at the child in care review and were informed that despite it being written down by the young person it was not discussed.

Compliance with regulations	
Regulation met	**Regulation 5**
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 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager and the staff team must ensure that they incorporate any actions identified at professional meetings into the young people's placement plans.
- The centre manager must ensure that young people are supported in line with centre policy if they raise concerns about the level of communication and support, they are receiving from their social worker.

Regulation 5: Care practices and operational policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

The centre had policies and procedures in place relating to the management of behaviours that challenged. While interviewing staff, inspectors found that they were knowledgeable of the policies in place and how to implement them effectively. Staff were trained in the policies and procedures and were trained in a suitable behaviour management model. Inspectors found that staff articulated well their knowledge of trauma informed care and responding to the young people's needs rather than the presenting behaviours.

Individual behaviour support plans (IBSPs), individual crisis support plans (ICSPs) and individual risk management plans (IRMPs) were in place as supporting documents for staff. Inspectors found that when interviewing staff about the interventions they used they were able to detail the practical things they did, however this was not outlined in the relevant supporting documents to the same understanding. Inspectors recommend a review of these documents to ensure the details given are clear and practical in how staff respond to any identified behaviours. This was not evident on some ICSPs where it detailed the behaviours but not what interventions staff should use. There was also confusion from staff when it came to completing checks on a young person where staff detailed the young person would be checked "regularly". However, it was not clear what regularly meant whether this was every hour or how frequently this should occur. Centre management must ensure all staff are responding to risk behaviours in the same way and that the relevant behaviour management documentation outlines those practical steps.

The IRMP's detailed any current risks to young people, and each had a risk rating for the current concern and a projected rating based on the interventions the team planned on utilizing. Inspectors found that the ratings were clear but there was no risk matrix system within the IRMP document to show what each level equated to, what the range was for each whether they were moderate, medium or high risk. This was outlined in the policy for risk management but no on the IRMP document.

As mentioned earlier, inspectors found that staff had a good understanding of the trauma the young people had endured and how their behaviours reflected that at times. It was evident during the file review and the interviews that staff understood the mental health issues presented, how to respond and deal with any bullying issues and how to respond to any disclosures made by the young people. In reviewing the incidents that had occurred for the young people, inspectors saw the trends that were identified by the staff for when the frequency increased in the number of incidents and how the young people were managing their behaviours. It was evident to inspectors for one young person, that there had been a decrease in the number of incidents since their admission as the reflective work staff were undertaking was having positive outcomes for that young person. On the other hand, there was another young person whose incidents had increased due to changes that had occurred for them. In response to this, professional meetings had occurred, and relevant services and supports were put in place for the young people. Specialist training was also being sourced to be able to best respond to the young person's needs, alongside updates made to their relevant risk and safety plans.

Inspectors found that as part of a safety plan for one young person, room checks were being completed by staff daily. These checks were not being recorded and inspectors recommend that this procedure is documented and outlines if anything was found during the room checks. In line with staff's response to this young person's risk behaviour, repeated safety plans were being created rather than the same plan being updated to reflect current risks which would be more useful for tracking the risk and response from the staff.

During team meetings, staff discussed and reviewed plans in place for the young people. This was one way that staff were updated on what was going on for each young person. Handovers and a communication book were also used as ways to inform staff what was going on for each young person and if any of their safety or risk plans had been updated. There was currently no audit completed around the centre's approach to managing behaviours that challenged however, inspectors were informed that as part of the compliance oversight process, all standards will be captured during their audits. A planned schedule was provided to inspectors around what themed based audits were to be undertaken from now until November 2025.

There was a comprehensive system in place for oversight and reviewing any restrictive practices in place. They were detailed in each young person's file and there was evidence of them being reviewed with decisions outlined as to whether they were to remain in place or if they could be removed.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- Centre management must ensure all staff are responding to risk behaviours in the same way and that the relevant behaviour management documentation outlines those practical steps.

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 was a new acting centre manager in place at the time of inspection and a new deputy manager. The regional manager was previously the centre manager and had a great understanding of the centre, the young people and the staff. There was evidence of leadership across the records with oversight from all those in management posts. Staff spoke of the support they received from management through supervision and when on shift. There were no young people in the centre for a period of time when it opened, and this allowed the staff time to become familiar with the running of the residential centre and with daily access to the management team for support. Staff spoke of how well this worked and prepared the team for recognising behaviours and for completing relevant documentation. One staff member that spoke with inspectors stated that as they had not worked in residential care previously, they were provided with supervision every two weeks as a way of developing and supporting them in their new role.

There were defined roles and responsibilities for the deputy, the acting manager and the regional manager. As part of ensuring good communication between them, the acting manager provided weekly governance operational reports to the regional manager which outlined supervision undertaken, any significant events, and updates on all the young people to name some of the areas addressed. Monthly monitoring reports were undertaken by the quality and assurance officer with an action plan attached for any outstanding tasks to be completed. Centre audits were undertaken on the young people's files, medication and supervision. Feedback was provided to the team on the centre audits however during interviews with staff, they were not aware of the audits or outcomes from the quality and assurance officer's audits.

There was a service level agreement in place with Tusla and six-monthly reports were required to show the centre was in compliance with the agreement, with legislation and the National Standards. The acting centre manager was identified as the

designated liaison person (DLP). The deputy manager and the two social care leaders were all identified as the deputy DLP. The centre staff named the social care leaders as the DLP. There must be a clearly identified person for each role and not a number of people for the deputy DLP role.

There was a suite of policies and procedures relevant to the running of the centre. Staff stated that as part of their induction process, they were made aware of and read the policies and procedures. Inspectors saw that different policies were discussed at team meetings.

There was a policy on risk assessment and risk management in place. The risk management framework required review as inspectors found that all staff interviewed did not have a good understanding of the processes involved with managing risks. There were IRMP's for each young person. These were relevant to each young person's presenting or previously known risk behaviours. However, there were no individual risk assessments in place for new or current risks identified. A system for assessing any new risks was needed with clear guidance for staff in how to practically respond, particularly for some of the young people with high risk concerning behaviours. The current safety plans lacked direction for staff and were documented like how risk assessment forms are recorded. In reviewing the team meetings, inspectors found that risk was not discussed and must be part of the meeting to ensure staffs awareness of the processes in place and how best to respond to the behaviours being presented. There was a centre risk register in place that was overseen by the acting manager.

There was a management structure in place relevant to the size and purpose of the centre. There was a plan in place for the deputy manager to step up in the managers absence if needed. There was a list of responsibilities and tasks outlined for the deputy manager when the acting manager takes leave. There was a delegation of officer roles/tasks in place which can be expanded on as more roles become applicable as the centre and staff develop.

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

Compliance with standards	
Practices met the required	**Not all standards under this theme**

standard	**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 there is a robust risk management framework in place to ensure risk is identified, assessed and managed appropriately, with clear practical directions for staff to follow.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Workforce planning was evident in the discussions at team meetings and at senior management meetings. Staff were informed of any vacancies and of any changes being made within the team as they occurred. Senior management discussed any ongoing issues with the team around vacancies and team development. Staff informed inspectors of the support they received from the acting manager, deputy manager and from the regional manager. One staff also spoke of the support they received from social care leaders while on shift which they found beneficial in their own development as a social care worker. Social workers informed inspectors they were made aware of any changes made to the team and in particular around the change in management. They spoke of meeting the same staff when they visited the centre and that their young people gave positive feedback about their interactions with the staff team.

During interviews with the centre manager and regional manager, they highlighted a vacancy for a social care leader role, a social care worker role and more relief staff. With the recent changes in management roles, this had created these vacancies. Currently the staff team consisted of an acting social care manager, a deputy manager, two social care leaders and six social care workers with two relief staff named. Relief staff were available to support the core staff team for annual leave, sick leave and for training purposes. On reviewing the staff information form and from the interviews with management, it became apparent that staff changes had

occurred since its first registration. One staff member did not have an appropriate qualification as outlined in the ACIMS Regulatory Notice on Minimal Staffing Level & Qualifications for Registration Children's Residential Centres August 2024. This therefore leaves the centre non complaint with the minimum number of staffing required. The registered provider must ensure that there are sufficient staffing numbers in place in the centre with the appropriate recognised qualifications.

The current staff mix included experienced staff, and some were new to residential care. There was an induction programme where staff were informed of the policies and procedures of the organisation along with an awareness of what was involved with their roles and responsibilities being part of the team working with young people. Mandatory training was undertaken by the team. Given the needs of some of the young people self-harm or Assist training would be recommended for all staff members to ensure they can manage the presenting behaviours. There was other training in ASD planned for the team to undertake to further develop their knowledge to support the young people.

The organisation had a staff retention policy in place. Staff spoke positively about their experience of working in this centre. They gave examples of ways the organisation supported the staff in their development through training, supervision, access to an employee assistance programme (EAP) and general support from the team when on shift. They spoke of enjoying working with the young people, the ethos of the centre and the environment in general.

There was an on-call system in place that was shared in the organisation between senior members of the teams. The system easily identified those on-call for the weekends however clarity was required for who covers on-call during the week as this was not known and not understood by all staff. Staff were aware of the on-call policy and reasons for when they needed to contact someone for support.

Compliance with regulations	
Regulation met	**Regulation 6** **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 there are sufficient staffing numbers in place in the centre with the appropriate recognised qualifications.
- The regional manager and acting centre manager must ensure that the on-call arrangements are documented, clear and known for evenings and weekends.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager and the staff team must ensure that they incorporate any actions identified at professional meetings into the young people's placement plans.	An audit has been completed via monthly monitoring report by the regional manager on the 11.11.2024 and shared with home management in relation to ensuring that any actions from care plans and other professional meetings are incorporated. Home management have commenced this process and evidence of same was observed during a recent placement planning meeting held on the 15.11.2024 in respect of one young person.	House manager will complete audits quarterly to ensure that all placement plans have appropriate actions included from care plans and other professional meetings. Regional manager will also conduct an audit on placement plans quarterly to ensure that this has been appropriately implemented.
	The centre manager must ensure that young people are supported in line with centre policy if they raise concerns about the level of communication and support they are receiving from their social worker.	Whilst staff and management did raise concerns with the Social Work Department on this young person's behalf, the young person themselves did not wish to make a formal complaint and therefore a formal complaint to Tusla was not made on their behalf, although the concerns were shared.	Where concerns continue despite staff and management reporting same, or where no improvement is noted, management to utilise the policy on complaints and submit a formal, notifiable complaint on behalf of young people via SEN where young person do not wish or do not feel comfortable making a complaint directly themselves.

			Alternatively, management to utilise the 'Tell Us' portal on behalf of young people.
3	Centre management must ensure all staff are responding to risk behaviours in the same way and that the relevant behaviour management documentation outlines those practical steps.	Regional manager completed an audit on the 30.10.2024 which focused on IRMP's, and this was shared with home management to ensure more clear, concise information has been incorporated to reflect the presenting risks specific to each young person and the appropriate measures and actions in place to mitigate these risks.	Managers will review IRMP's on a monthly basis to ensure that they are appropriate, accurate and up to date. These will also be reviewed regularly at team meetings to ensure that all staff are aware and have a good understanding of the risks and their responses to mitigate same.
5	The registered provider must ensure there is a robust risk management framework in place to ensure risk is identified, assessed and managed appropriately, with clear practical directions for staff to follow.	All staff have received induction training in relation to the risk management document including the assessment and grading of risk using the matrix. Regional manager conducted an audit on the 11.11.2024 to ensure that the risk matrix guidance is in place alongside the IRMP's and being shared with relevant professionals. Furthermore, where a new risk is identified that requires more in-depth action plans, a separate risk assessment will be completed to inform staff of the new risk identified and how to respond and manage the specific risk	The risk matrix guidance document has now been incorporated on to each young person's IRMP to evidence how risk has been assessed. Home managers will review these documents on a monthly basis and regional manager will complete external audits on a quarterly basis as an extra layer of governance and oversight to ensure all risks pertaining to young people are appropriately recorded with clear directions for staff on how to manage same. This will include ensuring that new risks have been identified and appropriate safety plans are in place where required.

		behaviour to ensure that there is understanding and consistency. This will enable staff to ascertain whether a specific safety plan is therefore also required. Both documents have been implemented with immediate effect.	
6	The registered provider must ensure that there are sufficient staffing numbers in place in the centre with the appropriate recognised qualifications. The regional manager and acting centre manager must ensure that the on-call arrangements are documented, clear and known for evenings and weekends.	Since the inspection, a Social Care Worker has commenced in the centre after completing relevant induction and mandatory training. The rota is sufficiently covered at present and additional relief staff have been recruited who will help support the core team. Staff member this relates to has previous and current experience in children's residential and is currently applying with CORU to be registered as a Social Care Worker. On call handovers are completed for each weekend highlighting the plans for each young person and the details for the on-call manager. This is also recorded on the monthly rota, so staff are aware of who the on-call manager is each weekend. During the week, managers and deputies are on	There continues to be ongoing recruitment across the company. A new recruitment manager is now in place to oversee recruitment and ensure staff are compliant with the appropriate recognised qualifications in line with each centre's statement of purpose and function. On call policy has been updated to reflect the responsibility of home management on call during the week. Regional management has oversight of the on-call rota to ensure this is appropriately covered at all times. Regional manager will complete audits as part of their monthly monitoring reports to ensure that the on-

		call for their homes and the person doing on call is confirmed during handover each day and is recorded on the handover book for staff each day.	call manager is being appropriately highlighted in handover for during the week.