An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 004**

**Year: 2022**

# Inspection Report

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| **Year:** | **2022** |
| **Name of Organisation:** | **Traveller Family Care** |
| **Registered Capacity:** | **One family up to a maximum of two parents and eight children** |
| **Type of Inspection:** | **Announced themed inspection** |
| **Date of inspection:** | **22nd & 23rd of November 2022** |
| **Registration Status:** | **Registered without attached conditions from the 31st October 2021 to 31st October 2024** |
| **Inspection Team:** | **Catherine Hanly**<br>**Cora Kelly** |
| **Date Report Issued:** | **7th February 2023** |

# Contents

# 1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance 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 2000. At the time of this inspection the centre was in its eighth registration and was in year two of the cycle. The centre was registered without attached conditions from the 31st October 2021 to 31st October 2024.

The centre was registered to accommodate a family of up to two parents and eight children at any one time. The purpose and function described the centre as providing a family assessment and intervention service in a family-based setting over a twelve-week period. The model of care was based on a defined assessment framework for which training and clinical oversight was provided. One family consisting of two parents and two children were residing at the centre at the time of this inspection.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| Theme 5: Leadership, Governance and Management | 5.2 |
| Theme 6: Responsive Workforce | 6.4 |

Inspectors reviewed documentation and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including centre manager, Director of Services and social care staff. 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 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, and to the centre manager on 12th of December 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 Director of Services returned the report with a CAPA on the 23rd of December. Inspectors requested additional supporting documentation and information, and the completion of the staff team training needs analysis prior to finalising this report.

The findings of this report and assessment of the submitted CAPA with additional supporting information 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: 003 without attached conditions from the 31st October 2021 to 31st October 2024 pursuant to Part VIII, 1991 Child Care Act.

## 3. Inspection Findings

**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**

There was an experienced and committed manager in post for many years and they had overall accountability and responsibility for the delivery of the service in this centre. The manager had led out on the change to the centre's purpose and function several years prior, during which time, and since, they had continued to provide leadership to the staff team in their service delivery. The director of services had also been in post for many years, having managed the centre prior to that, and was continuing to provide stability in terms of service provision. The staff members interviewed identified the manager as good, reliable, and available to them in providing any direction and guidance as needed. There was a recently signed off service level agreement in place between centre management and Tusla as the contractor, and inspectors were informed that a meeting would be convened as part of this agreement to enable Tusla to receive relevant information in terms of the service's compliance with relevant legislation and the relevant aspects of the national standards.

There was a governance structure in place whereby the centre manager reported to the director of services on a regular basis and the director reported to the board of management. The centre manager also submitted reports consisting of service overview for the quarterly board of management meetings. These reports were largely based on an update of the family in situ at the time of the meeting. The centre manager had completed audits of supervision files and whilst there were clear actions identified there was no plan of implementation. This plan must be included here. Audit reports following the completion of the family assessment by the centre manager although brief, did give an account of the application of the service in accordance with its stated purpose. Inspectors recommend that this format be expanded upon to include any actions arising, outcome of the placement and any

learnings that needed to be brought back to the team and/or incorporated into service development.
The inspectors found that the director of services was available to the manager and staff team, and knowledgeable about the families that had accessed the service. Inspectors reviewed the director of services job description and found this to be quite broad, vague, and outdated as it did not refer to the assessment model in use in the service. Inspectors recommend that a review of the director of services job description so that it reflects the updated nature of the service being provided.

The director of services had devised, but not fully implemented an auditing system which had been committed to following the inspection of the service in 2021. There were five audits of individual family placement reports which focused on the progress of the family throughout the assessment but did not give an assessment of the application of the service itself. The director had also commenced a compliance report with a service improvement plan included. This plan was incomplete at the time of the inspection and, based on this inspection and review of policy and practice therein, was an insufficiently robust audit of service compliance. Whilst these reports are informative from a family progression perspective, they do not fulfil the criteria required to demonstrate robust service governance.

Inspectors reviewed the compliance report which had recently been completed by the director of services. This report, set against the national standards was found to have lots of content that was not applicable to this service due to its purpose and function. Elsewhere, there was no reference or comment on policies and their stage of development although inspectors noted these still requiring significant development. The section on training did not identify any training needs and yet staff and the manager named that there were training needs, and these were highlighted separately in a training audit. Inspectors found this report to be insufficient to provide sound information on the activities of the service and generating learning and service development.

The staff members interviewed were extremely knowledgeable about all aspects of their role and the service and demonstrated a clear commitment to their own learning and professional development. They clearly understood their internal reporting systems and were aware of oversight of their work by the centre manager. However, there was no evidence of feedback or learning provided to the staff team based on either type of report referenced above completed by the director of services or separately to indicate input of the board of managements' oversight of the service delivery. Overall, inspectors found that reports generated by the centre manager and

director of services were focused on the families that participated in the assessment process, as opposed to a focus on governance by way of concentrating on the delivery of the service itself. The director of service must implement a robust auditing mechanism that gives an accurate account of service provision and an action plan that has clear timeframes identified.
Inspectors found that the development of policies and procedures as a document was ongoing. There was no date on the documents provided to inspectors and some reviewed by inspectors required more guiding detail for the staff team. For example, it would be good to put timeframes on the induction process for new staff. In other policy areas, like auditing under governance, inspectors found that the policy outlined had not been realised in practice. The policy on staff training and development had not been completed. Inspectors suggested that the centre manager consider liaising directly with a family assessment service regarding the development of policies and procedures to ensure they are in line with regulatory requirements, take account of the national standards and relevant guidelines but are also matched to the unique purpose and function of this service. Centre management must put a plan of development and implementation in place that includes timelines for completion and regular review of all policy and procedure documents.

Inspectors were informed by centre management that Tusla, The Child and Family Agency, has approved funding to the service for the specified purpose of implementing a fulltime deputy manager post and two social care leaders' posts. The centre manager and director of services were of the view that these developments will, when introduced in 2023, significantly augment the internal management structure. At the time of this inspection the deputy manager was the delegated person responsible for covering for periods when the manager was absent and they, along with identified members of the staff team, had tasks and areas of responsibilities delegated to them. There was a template on file for recording the delegation of duties which was not in use. This template should be implemented without delay and kept under review so that it remains a live document.

The inspection of this service, one-year previous, identified risk management as an area requiring development. Inspectors found that the staff members clearly understood and described their role in the identification and management planning of risk. There were review systems in place and documents were updated accordingly with all relevant parties informed. Staff members in interview spoke about the importance and value of risk assessments in their daily work. There was some disagreement between the centre manager and staff over one practice employed, and inspectors recommend that this practice is included as part of the standard suite of

risk assessments completed upon a family's admission and should be subject to review in the same manner as other risks.

Inspectors were of the view that the existing risk matrix utilised to inform centre and organisational risks was limited and would benefit from expansion. From their review of the centre and organisational risk registers, inspectors noted that the detail included in the registers needs to be more concrete, for example stating the date the risk was identified. Inspectors also pointed out to management that where a risk management plan was in place and had been effective in reducing the risk, the risk itself was not 'closed' until the risk, as identified, had been fully eliminated. Centre management must review the content of their existing registers and ensure there is a system of regular review in place going forward.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 5**<br>**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 board of management must review and update the job description for the director of services.
- The director of service must implement a robust auditing mechanism that gives an accurate account of service provision and an action plan that has clear timeframes identified.
- Centre management must put a plan of development and implementation in place that includes timelines for completion and regular review of all policy and procedure documents.
- Centre management must ensure that a written record is kept when, and to whom, duties have been delegated and the key decisions made.
- Centre management must review the content of their existing risk registers and ensure there is a system of regular review in place going forward.

**Regulation 6: Person in Charge**
**Regulation 7: Staffing**

**Theme 6: Responsive Workforce**

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

Inspectors found evidence of regular attention to staff training. This was recorded consistently in team meeting minutes as a topic for discussion and was reported by staff in interview as having been discussed in their individual supervision on a regular basis. Staff members were encouraged to attend available training, including free training that had recently become available to the staff team through the online HSE training programme. It was acknowledged by centre management that there was no allocated training budget available within the operational finances to support the staff team in receiving appropriate training and development opportunities, equivalent to their role in this service. There was evidence of a strong commitment by staff members to their own individual professional development and inspectors found that the staff team were committed to the delivery of a high-quality service as well as their own continuous professional development. Ongoing individual training and learning were brought to formal supervision for reflection and learning. This reflection should equally be brought to team meetings to ensure that all learning is consistently shared amongst the team. Inspectors recommend that the commitment to training and learning should be supported in a formal capacity by centre management in the ongoing development of policy and programme of training and continuous professional development.

Inspectors noted that the training needs analysis completed by centre management in September 2022 and an updated training list for November 2022 did not correspond exactly and, for centre management to be able to adequately respond to identified training and development records maintained in the various locations/formats must be consistent. Inspectors noted that the training audit identified areas of training to be addressed, including securing of certificates for individual files, and first aid and ligature training for identified staff members. No timeframes for completion had been assigned to any area of need identified. In interviews, the centre manager and staff members also identified the need for refresher training in the assessment model utilised in the centre. This need had not been identified in the training audit or the service compliance report recently conducted by the director of services.

The centre had a formal policy on induction for new staff. Inspectors found that this policy was realised in practice for the most recent staff that had commenced working in this service. There were no timeframes outlined for the induction period and it would be beneficial to include these.

Based on the findings of this inspection centre management must conduct a robust analysis of all staff training and development needs equivalent to the role of staff members in the delivery of this assessment service. The analysis must include a clear timeline of when the identified training needs will be completed. Inspectors recommend that the director of services secure or set aside funding for specific and prioritised pieces of training that the staff team require. This includes refresher training in the assessment model and bespoke child protection training that incorporates the services' purpose and function and their own policies and procedures.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 6**<br>**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**

- Centre management must conduct a robust analysis of all staff training and development needs equivalent to the role of staff members in the delivery of this assessment service. The analysis must include a clear timeline of when the identified training needs will be completed.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| 5 | The board of management must review and update the job description for the director of services. | To be completed and brought to the next Board of Management (BOM) meeting in January and to be passed by the BOM. – Early February 2023. | The BOM will review and pass the same. |
| | The director of service must implement a robust auditing mechanism that gives an accurate account of service provision and an action plan that has clear timeframes identified. | This will commence the end of January and audits will be completed throughout the year,<br>Report will be issued to SCM who will be given a time frame of two week to respond.<br>The DOS will follow up on the same in relation to compliance and give feedback. | The DOS will, follow up with SCM give feedback and await responses; implement action plans with agreed timeframes SCM report her findings to the BOM and give feedback to the team. |
| | Centre management must put a plan of development and implementation in place that includes timelines for completion and regular review of all policy and procedure documents. | To be completed by end of February 2023<br>Research/engage with various agencies providing similar service at beginning of January, to be completed by end of February 2023.<br>Incorporate simple standard operating procedures to support relevant policies. | Set up yearly policy review/steering group including director, management, members of the staff team to ensure adequate and timely review of centre policy and procedures. |

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|---|---|---|---|
| | | Complete by end of February 2023. | |
| | Centre management must ensure that a written record is kept when, and to whom, duties have been delegated and the key decisions made. | Develop a template that will record decisions made, duties assigned to whom and when tasks will be completed by.<br>Have in operation by 13th January. | Devise policy around delegation of duties which can be reviewed as part of the yearly review group – evaluate tool how is it working, make necessary changes from learning. |
| | Centre management must review the content of their existing risk registers and ensure there is a system of regular review in place going forward. | Review Risk Register and update – to be completed by 23rd of December 2022.<br>Develop policy on risk registers that clearly outlines framework in which it operates.<br>Develop standard operating procedures that sets out regular review system, time frames for review, action plans necessary. | Review risk register at monthly managers meetings.<br>Review policy each year as part of the yearly policy review group. Learning from risk register, identify any changes and action plan for implementation. |
| **6** | Centre management must conduct a robust analysis of all staff training and development needs equivalent to the role of staff members in the delivery of this assessment service. The analysis must include a clear timeline of when the identified training needs will be completed. | Analysis of core training to be completed by end of January 2023 and training dates for completion identified.<br>Identify additional training needs at team meeting on the 10th of January 2023 and from here develop additional training needs schedule. Identify training dates and book training. | Set up yearly training review group including director, management, members of the staff team to review training needs achieved or outstanding and identify training needs for the upcoming year.<br>Allocate a yearly training budget to support team in accessing additional training identified as part of the needs assessment. |