An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 014

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Focus Ireland**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Announced**
Date of inspection:	**3rd & 4th of February 2022**
Registration Status:	**Registered from the 13th of March 2022 to the 13th of March 2025**
Inspection Team:	**Eileen Woods** **Lorraine Egan**
Date Report Issued:	**29th March 2022**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in January 2002. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from the 13th of March 2019 to the 13th of March 2022 and was applying for their registration renewal at the time of this inspection.

The centre was registered as a multi-occupancy emergency service. It aimed to provide emergency accommodation for up to a maximum of four young people aged sixteen and seventeen years old on admission. Referrals were received through the Tusla National Out of Hours (NOHS) and Crisis Intervention Service (CIS). The length of stay was three nights with re-referral required for longer stays, up to seven days. The centre operated a model of positive youth support. There were three young people living in the centre at the time of the inspection and a total of fifty-six admissions had taken place at the centre in the preceding twelve months.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.1
4: Health, Wellbeing and Development	4.2

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 on the 8th of March 2022 and to the relevant social work departments on the 8th of March 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 22nd of March 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: 014, without attached conditions from the 13th of March 2022 to the 13th of March 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to, and complaints are acted upon in a timely, supportive and effective manner.

Inspectors found that the commitment and experience base of the management and staff was evident in how they worked directly with young people. The centre had an established culture of respectful, non-judgemental and responsive emergency work with young people and young adults in crisis.

There was a structure evident that listened to and took account of the individual immediate and urgent needs and views of the young people at a difficult juncture of their lives. The staff team created records of this through individual work, key work records and daily logs. On these records there was evidence of contact with family members where that was possible. Young people were prompted and supported to attend their planning meetings, these were held fortnightly if a placement went beyond the initial 3-to-7-day timeframe, their wishes and requests were represented by staff at these and other meetings also. Staff had a concrete example of change generated from listening to young people, that following consultation with young people the centre were moving from pre catered meals to cooking by the team day to day. This is due to commence at the end of February 2022.

There was a booklet and admissions processes for the young people to inform them of what they can expect at the centre, their rights and centres expectations of them during their stay. The staff stated that they had a prominent role in being advocates for the young people even in a short window of opportunity. They completed admissions processes that informed young people of their right to complain, told them about the Tusla complaints procedure 'Tell Us', informed them about the advocacy service empowering young people in care, EPIC, and about the ombudsman for children office. The young people were supported with making complaints about other bodies like the Gardaí through the relevant ombudsman office for same.

The centre management group had evidenced consistent and sustained service improvements over recent years. They recorded this through a service improvement

plan and quality assurance audit processes but one aspect that was not fully accounted for yet within this was how input from young people will be utilised at all levels to raise awareness and inform improvements.

Inspectors found that there was a complaints policy in place, it had been identified for review and as not being fit for purpose by staff since June of 2021. The team named that they found the procedures confusing in places. Inspectors found that the complaints policy stated that best practice would be to resolve complaints informally and to build this into the culture. And that all complaints, verbal or written, were to be logged and stored, thereafter, to be monitored and reviewed by staff, managers and the external line manager. These procedures were not achieved in practice inspectors found. The complaints log had one entry in 2021, entered as resolved within four days and closed. Inspectors established from file review and from interviews that the team were unclear in how to identify, process and record complaints of all types.

Young people were informed that complaints related to any aspect of their care that they were dissatisfied about, and the goal would be to resolve it there and then and if not that it would be escalated to a more senior staff to address. Whilst there was evidence to demonstrate that young people were listened to inspectors found that this was within a semi structured framework that was individualised depending on the staff involved and this needs to be improved. There were examples of better practices emerging, for example in social care leaders seeking to identify and respond to complaints and in record keeping by all staff however improvements are required to bring the policy, procedures and practices in line with each other and in a manner that will be best suited to the service type.

Inspectors therefore found some evidence of complaints being recorded, managed and discussed but this was limited. There was no formal system for escalation to management or to senior management, there was no current structure evident at each management level of tracking, reviewing or learning from the outcomes of young peoples complaints. During the inspection the team and management acknowledged gaps in the process and system for capturing complaints and were committed to taking action to ensure that their stated commitments to young people's complaint's being taken seriously and being listened to were fully evidenced in practice.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
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 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The senior management team must ensure that they establish a means by which feedback gathered from young peoples and families is utilised to inform the ongoing service development plan.
- The centre management must review and agree a policy on complaints that is then implemented in practice. Complaints must be recorded and responded to in accordance with the policy with learning identified and changes made where appropriate.
- The centre management must ensure that there is a commitment to training and development in the complaints policy and practice.
- Focus Ireland must ensure that there is a formal system for escalation of complaints and information from outcomes of complaints to management and to senior management to support accountability, tracking, reviewing and learning.

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

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

At the time of the last inspection in February 2021 it was identified by inspectors that the child safeguarding policy was not fully in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 with regard to the role of staff as mandated persons. During this 2022 inspection it was found that a policy addition had been circulated to staff in January 2022 regarding the role that all social care staff have as mandated persons. This represented a significant amount of time to complete a CAPA commitment that could have been implemented for this centre more rapidly.

There were two policies at the time of this inspection with the previous child safeguarding and the updated child safeguarding policies not amalgamated fully. Inspectors found that both needed to be reviewed side by side to bring clear procedures forward on allegations made against a staff, mandated persons and mandated reporting. The recording and tracking of information under the threshold and procedures for escalations in the event of non-responses to child protection reports also need to be contained clearly within the policies when brought together. Inspectors additionally recommend that the policy on protected disclosures be maintained with the suite of child protection policies. Inspectors found that the management must have a clear system for recording allegations that they determined did not meet the threshold for reporting and why, presently such a system does not exist.

The centre did not have a policy on bullying included with the suite of child safeguarding policies and this had been listed for action by quarter two 2021. This must be completed and placed with the policies without further delay. There was evidence that ongoing team training in the centres safeguarding policies was required as it was evidenced by inspectors that staff remained unclear on certain procedures or points of detail from within the policy documents. Whilst there was no policy on anti-bullying the team demonstrated an awareness of the potential for this and tracked relationships between young people if a concern was identified.

There was a record of training maintained and this identified that all staff required either renewals in or to complete the mandatory national training module Introduction to Children First eLearn through the HSELand training portal. The training deficits must be addressed without delay including training related to the approved method of management of challenging behaviours. Once the policy suite is updated all staff must be provided with internal training in these, without delay, in 2022. The services risk register stipulated that there would be compulsory training on child protection as well as periodic review of child protection reports for

consistency and compliance. The services standards officer completed two audits out of a planned four audits in 2021 due to the impact of the pandemic. The senior services manager was to complete monthly interim audits which were also impacted by the pandemic. Therefore, although there were audit actions and an audit tracker as well as reporting and meetings between the senior services manager and the centre manager there was a gap in this type of planned oversight of child protection reporting and policy compliance.

There was a section for each young person at the weekly team meetings on child protection and on safeguarding through which staff and management sought to place child protection and safeguarding at the heart of their work and to track it. Inspectors recommended some improvements to these records to ensure that they link well to any reports submitted through the portal during a young person's stay or to any significant event reports issued for information under the threshold. The team maintained a child protection and welfare reporting register and an excel tracker. These must be overseen by a manager through to follow up and closure and required improvements.

Staff and management displayed their strengths in how they worked in partnership utilising an interagency and multi-agency approach. The experienced staff provided leadership and learning for new staff on this approach to the work. The meetings held were central to the promotion of safety, the naming and addressing individual areas of high vulnerability and advocating for young people's right to a safe place to live. There was a robust schedule of meetings held if a young person did not move onto a stable placement urgently. The teams key focus was to minimise stays and to work to stabilise risk and where possible mitigate or reduce risk for young people whilst availing of the service. The team maintained standing risk assessments on the physical location and other specific influencing factors such as substance misuse and these advised the work of the team day to day. Individualised risk and safety plans were created for young people particularly through the use of rapid risk assessment.

The centre had been purpose built as a hostel and had CCTV internally and externally, these were clearly advertised by signage and were governed by a policy that took account of relevant legislation and best practice. The centre had security systems at the front entrance that also aimed to enhance safety. The building itself had been identified for renovation and the plans for this were at an advanced stage at the time of this inspection, no timeframe could yet be assigned for this though.

The centre had a policy on protected disclosures, a copy of which was provided to inspectors upon request. The staff team were aware of the intention of the policy but not the persons designated within the organisation to whom they could go. This policy must form part of the overall internal training on child safeguarding when undertaken.

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 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor and centre management and the organisations policy and standards team must ensure that the 2021 and 2022 child protection and safeguarding policies and procedures are amalgamated to ensure clear, robust and compliant policies are in place.
- The registered proprietor and centre management must create a bullying policy and add this to the suite of child protection and safeguarding policies and procedures.
- The registered proprietor with centre management must ensure that training is resourced and completed by the team in all aspects of child protection, safeguarding and trauma to enhance their work with vulnerable young people.
- The centre management must ensure that training in the approved method of management of challenging behaviour is completed for all staff.
- The centre management and senior management must ensure that the identifying, recording, tracking and reviewing of children first and child protection and safeguarding policy compliance forms part of their work.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

Due to the emergency nature of the service provision at the centre there was an absence of care plans in general due to the time frames around admission and discharge being typically three to seven days. For those young people not moving within the time frames it was unclear if these were sought as a matter of course or not when it became clear that the move from the centre would become protracted. What was evidenced on file was a clear admissions process and well-structured format for staff to capture any existing health services, appointments, or immediate health needs that young people might have upon admission. The staff established from the outset if the young peoples had GP's, where those GP's were located and what resources would be needed to ensure young people maintained their own GP including how to get to appointments of all types. The centre also had a local GP who accepted young people who did not have a GP practice that they were registered with or was not within reach.

The staff team worked in partnership with the national out of hours, NOHS, and its crisis intervention service partnership, CISP, to provide social workers or staff to accompany and transport young people to medical or mental health appointments. The centre also looked to the allocated social workers and their social work areas for support in this.

The centre management had sourced information including any assessments related to the young people to advise preadmission risk assessments, risk management and planning. On the four files reviewed there was information on previous diagnoses, previous medications, current appointments and referrals for hospitals, GP's, counselling, CAMHS, YODA, dentists, optical and other relevant aspects of health care. Due to the rapid turnaround of the centre only the information critical to staff and young people's day to day work was maintained on the working file, the rest was maintained confidentially.

Through some of these records inspectors could see risks including those in health, mental health, addiction or substance misuse concerns were kept in focus. There was evidence that the team spoke clearly, openly and in an age-appropriate way with the

young people in signposting supports. Where young people had specialist services in place the staff promoted and facilitated attendance. Through the daily records and the weekly team meetings a clear track was kept of young people's diet and overall, wellbeing and presentation. The social workers were kept informed through phone calls, planning meetings, written updates and significant event reports. One social worker outlined how although initially their young person could not be admitted that the centre manager had been in contact, conducted a risk assessment, sought further information, and provided guidance. The staff and management held a good awareness and risk awareness regarding the location of the centre as an additional risk factor if a young person had some substance misuse issues.

The staff team demonstrated that mental health awareness regarding self-harm and suicide awareness was a high priority for them as a team and a recurring issue for several young people. There was evidence on the centre records of staff actions displayed through planning for the day and night shifts and through the use of planning for safe care. The safety planning included individual crisis management plans, safety plans and risk management plans. These expanded planning tools like the risk management plans were utilised once a young person had not moved from the centre within the timeframes or immediately if a young person presented with self-harming or with suicidal thoughts. Inspectors found that staff had put emergency measures in place onsite during high-risk nights and maintained a good record of this. They did so through the use of rapid risk assessment to generate a safety plan. The staff coming on after this took this safety plan forward and continued to address and act on the needs in direct consultation with the young person involved. The inspectors found that the night-time records were clearer in some instances and that the staff must remember to record the daytime checks to a similar safety standard, for example when a young person kept under close observation, in a common area overnight, moves to a bedroom during the day.

There were policies in place on medical attention, administration of medication, health and wellbeing, first aid and drugs and alcohol. The staff team had completed a review of the administration of medication procedure at a team meeting in the Autumn of 2021. Inspectors found though that in practice there were key and crucial differences in understanding between the management and the team regarding what medications could and would be kept at the centre, where they would be stored and how they would be managed overall. There was a procedure for the emergency treatment of an overdose with a medication used to reverse the effects of opioids which staff at interview were not familiar with. The centre management must ensure that there are a clear procedure and a shared understanding of how these are

implemented on the ground. Management must also ensure that internal training be provided on the availability and use of this intervention. There must be a review of the training and equipment best suited to self-harm and suicide awareness and procedures for same. A regular tailored means of auditing practices in this area must also be introduced.

The matter of a budget for the centre was unclear regarding who might purchase over the counter medications like paracetamol, vitamins or supplements recommended for young people.

Compliance with regulations	
Regulation met	**Regulation 10**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must ensure that there is clarity on procedures for non-prescription medications, prescription medications and storage and administration of both.
- The centre management must ensure that there is robust understanding of and system in place through policies and any necessary training for the administration of the treatment to reverse the effects of overdose.
- Focus Ireland must ensure that the team have access to relevant training as required related to trauma, self-harm and suicidal ideation.
- The centre management must ensure that there is a system for routine audit of medication and related aspects of health care.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The senior management team must ensure that they establish a means by which any feedback gathered from young peoples and families is utilised to inform the ongoing service development. The centre management must review and agree a policy on complaints that is implemented in practice. Complaints must be recorded and responded to in accordance with the policy with learning identified and changes made where appropriate.	An interim measure with immediate effect will see complaints/feedback as a standing item at the management group meeting and the weekly team meeting. This will also capture issues that are raised at the informal level. Immediate. A new system is being developed in conjunction with Service Standards and Practice Development called Your Service, Your Voice: this seeks to understand what worked, what we could improve and what didn't work. The emphasis is to remove the negative focus on complaints being about 'what's wrong'. This is forming part of a wider Youth Participation Strategy which seeks to inform service development from the Young Persons perspective.	Your Service Your Voice will form part of the Audit process. The Annual Service Review will have it as a section with reference to Service Development. Persons involved: Centre Management & PPIM Service Standards and Practice Development Office Youth Participation Group Young People in Centre (this group will vary given nature of the service)

		Where practicable it will seek other stakeholders including carers input whilst acknowledging that many carers are not involved with the young person when admitted to Caretakers. Work had previously commenced in terms of a wider complaints review.	
	The centre management must ensure that there is a commitment to training and development in the complaints policy and practice.	The new framework will incorporate training and in-built mechanisms to escalate issues to the appropriate level with Focus Ireland and to form part of the Annual review process. End of Q2 with roll out in Q3 2022.	
	Focus Ireland must ensure that there is a formal system for escalation of complaints and information from outcomes of complaints to management and to senior management to support accountability, tracking, reviewing and learning.	An interim measure with immediate effect will see complaints/feedback as a standing item at the management group meeting and the weekly team meeting. This will also capture issues that are raised at the informal level. Immediate	
3	The registered proprietor and centre management and the organisations policy and standards team must ensure	The new 2022 child protection and safeguarding policy has already been incorporated into the P&P. At the time of	Policies have been mapped to incorporate good practice from previous policy. Policy review in place annually.

	that the 2021 and 2022 child protection and safeguarding policies and procedures are amalgamated to ensure clear, robust and compliant policies are in place.	inspection, it was being rolled out with the team and only gets added to the main P&P suite following discussion at Team meeting. This has now occurred March 2022.	
	The registered proprietor and centre management must create a bullying policy and add this to the suite of child protection and safeguarding policies and procedures.	Draft policy currently in development. End of Q2 2022.	Annual review of all Centre Policies occurs July every year and this ensures policies & procedures are up to date and incorporate best practice.
	The registered proprietor with the centre management must ensure that training is resourced and completed by the team in all aspects of child protection, safeguarding and trauma to enhance their work with vulnerable young people.	All staff are undertaking Mandated Person eLearning module via Tusla. End of April 2022. Focus Ireland Child Protection refresher training May 2022. New staff previously enrolled for the 2-day Child Protection training Safeguarding Conversation ½ training FI June 2022. New staff enrolled on TCI training April 2022.	Training review annual to ensure staff up to date in core training and refreshers.
	The centre management must ensure that training in the approved method of management of challenging behaviour	Refresher training to be booked when new Q3 TCI calendar launched.	Training review annual to ensure staff up to date in core training and refreshers.

	is completed for all staff. The centre management and senior management must ensure that the identifying, recording, tracking and reviewing of children first and child protection and safeguarding policy compliance forms part of their work.	 Audit dates established for in-person audit 26th April 2022 with follow up management meeting and QIP 6th May 2022. 10th August 2022 with follow up management meeting and QIP 26th August 2022. 22nd November 2022 with follow up management meeting and QIP 9th December 2022.	
4	The centre management must ensure that there is clarity on procedures for non-prescription medications, prescription medications and storage and administration of both. The centre management must ensure that there is a clear understanding of and system in place through policies and any necessary training for the administration of the treatment to reverse the effects of overdose.	Review medication policy and practice at Team meeting March 2022. New staff to receive Naloxone training Naloxone practice to be reviewed at team meeting. Completed.	Medication is tracked twice per day currently. Current & ongoing New Quarterly audit of medication safe to occur. Immediate.

	Focus Ireland must ensure that the team have regular relevant training as required related to trauma, self-harm and suicidal ideation. The centre management must ensure that there is a system for routine audit of medication and related aspects of health care.	All staff will complete LivingWorks Start training on suicide awareness Q2 2022 Focus Ireland rolling out agency wide trauma informed care (in development). If a YP is on medication when admitted to Centre it is counted at handovers to ensure accurate tally with medication logs (current practice). Weekly review by centre management of records (current practice). Weekly team meeting will highlight issues arising and corrective action. Immediate.	