An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 018

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Kellsgrange**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**20th and 21st and 28th February 2023**
Registration Status:	**Registered from 11th April 2021 to 11th April 2024**
Inspection Team:	**Linda Mc Guinness** **Joanne Cogley**
Date Report Issued:	**1st September 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 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 the centre with the standards and regulations and the operation of the centre in line with its registration. The centre was first registered in 2015. At the time of this inspection the centre was in its third registration and in year two of the cycle. The centre was registered without attached conditions from the 11th of April 2021 to the 11th of April 2024.

The centre was registered as a multi occupancy centre to accommodate four young people from age thirteen to seventeen on admission. The model of care was described as a trauma informed and relationship based. The model was underpinned by a theoretical approach across five core themes: food and mealtimes, the home environment, boundaries, language, and relationships. At the time of inspection there were three young people living in the centre.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2.
5. Leadership, Governance, and Management	5.4
6. Responsive Workforce	6.1 & 6.2

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.

This inspection set out to inspect against standards 3.1 and 3.2 of the National Standards for Children's Residential Centres, 2018 (HIQA). However, when onsite, concerns arose in respect of governance and staffing and the inspection was expanded to include standards 5.4, 6.1. and 6.2.

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 March 2023. 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 inspector wrote to the centre on 27th April 2023 as a CAPA due by 11th April was not provided. A CAPA was subsequently provided by the registered provider on 09th May 2023.

The preliminary findings of this report were that the centre was not in keeping with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: *Care Practices and Operational Policies*, Article 7: *Staffing* and Article 16: *Notification of Significant Events*. As a result, this centre was referred to Tusla's National Registration Enforcement Panel and the registered provider attended a regulatory enforcement meeting on 03rd March 2023.
At this meeting the provider stated that it was their intention to cease operations in this centre. The registered provider also voluntarily agreed that there shall be no further admissions to the centre and had committed to improvements in service governance. The provider later indicated that negotiations had been commenced with the child and family agency to transfer its management. This process is ongoing.

This centre will remain registered while under review by Tusla's National Registration Enforcement Panel. If the centre has either not ceased operations or transferred to the Child and Family Agency on or before 16th November 2023 it will be subject to further inspection activity.

3. Inspection Findings

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.

Inspectors found that the centre was not operating fully in line with the relevant legislation or complying with reporting procedures set out in Children First: National Guidance for the Protection and Welfare of Children, 2017 or in line with the requirements of the Children First Act, 2015. There were deficits in relation to staff understanding of their responsibilities, vetting processes and procedures, and reporting child protection and welfare concerns.

The centre had policies and procedures on child protection and welfare and had set out principles to safeguard children from harm. These were generally in line with the requirements set out in Children First: National Guidance for the Protection and Welfare of Children, 2017. However, they should be revised to also include appropriate vetting of staff who have worked in other jurisdictions.

The child protection policies included reference to a rigorous recruitment and selection process that included: an interview process; verification of qualifications and validating all relevant information. Inspectors found however that the centre was not in compliance with policy and that robust recruitment practices to safeguard children were not in place. This is further discussed under standard 6.2 of this report.

Inspectors found also, there was inadequate oversight of personnel files. Inspectors were informed that the employment of a dedicated person with responsibility for HR was discontinued due to financial constraints within the company. Suitable alternative arrangements were not implemented. The centre's policy document stated that '*The Managing director of Services was the person responsible for leading the development of the child safeguarding procedures and for ensuring that policies and procedures are consistent with the best practice*'. It is the assessment of inspectors that this was not evident in practice during inspection.

There was a written Child Safeguarding Statement (CSS) dated January 2023 that was displayed in the centre as required and that was approved by the Child Safeguarding Compliance Unit (CSSCU) of Tusla. The statement was reviewed and updated in line with statutory requirements. While the statement set out the potential risks of harm/abuse, as defined under the Children First Act, 2015, inspectors found that staff, managers, and the registered provider were not familiar with or able to describe them in interview. Following a review of the centre's CSS the inspectors found it did not include the risk of child sexual exploitation. This was a potential risk at the time of inspection and the centre manager must ensure it is incorporated into the current Child Safeguarding Statement.

There was a procedure in place to maintain a list of all mandated persons in the centre. Inspectors found that this list contained a person who was not mandated by virtue of their role as a maintenance person and this must be amended and communicated to them.

The organisation had sourced external training in respect of child protection and safeguarding. However, the manager informed inspectors that this was not of a good enough standard and had to be repeated. Inspectors found that this possibly added to confusion among staff about their responsibilities as mandated persons in relation to reporting child protection and welfare concerns. During inspection interview, most staff were of the understanding that a report could only be made jointly with the designated liaison person (DLP) who was the centre manager, and not independently in their own right if required. In some instances, the DLP had written and submitted a child protection referral on the Tusla Portal with information they received from a third party. This practice is not in line with Children First, 2017 and must cease.

Social workers confirmed in interview that there were clear procedures in place whereby they would inform parents/guardians of any incident or allegation of abuse.

There was a lack of evidence that staff and managers were fully alert to individual safeguarding concerns and vulnerabilities of young people. Inspectors found that individual vulnerabilities for some young people were minimised, not recorded, or inaccurately recorded and did not facilitate effective planning from a safeguarding perspective. While there were individual risk assessments to address some areas of vulnerability for young people, there was a lack of evidence that these were subject to regular review at team meetings. There were deficits in respect of safeguarding relating to intimate care of one young person with no risk assessments and safety

plans relating to this issue. At the time of inspection there was no policy or procedure to guide staff practice relating to intimate care of young people, if required.

The centre had written policies and procedures in place to address all forms of bullying. However, inspectors found from review of care files and through inspection interviews that bullying was a concern, but it was not managed in line with the centre's own policies and procedures and monitored to assess if it met reporting thresholds under Children First, 2017.

The inspectors found that there was serious under reporting of significant events for all young people, some of which constituted child protection and welfare concerns. These were not notified through the significant event reporting mechanism and referred to Tusla through the portal, in line with Children First: National Guidance for the Protection and Welfare of Children, 2017. There were insufficient measures in place to address the risks both internally and through joint strategy meetings with supervising social work departments.

While the Director of Service had disseminated the Tusla Child Sexual Exploitation Procedure, 2021 to managers by email there was no evidence that this was communicated to the team. During interview, neither the management team nor staff were familiar with the document and associated checklist, and there was no evidence that identified risks had been assessed to determine if they met the reporting threshold under the protocol. A review of case files and interviews with supervising social workers and a Guardian Ad Litem indicated that this was a risk that was not assessed recorded, reported, or monitored appropriately.

Inspectors did not find adequate oversight of reported child protection/welfare concerns at team meetings, senior management meetings or as part of an external auditing process.

There was a register of child protection referrals however supporting documentation was not held on file in the centre and some reports did not contain details of the person alleged to have caused harm. There were seven referrals in respect of one young person, however, there were no records of the submission on the Tusla Portal and no evidence of follow up with the supervising social work department. There was no mechanism for recording child protection concerns that were determined not to meet the threshold for reporting under Children First: National Guidance for the Protection and Welfare of Children, 2017.

The centre had a range of written policies to safeguard the young people in the centre such as safe practice and working alone, bullying and harassment, disclosures and allegations of abuse and protected disclosures. However, inspectors found that these were not evident in practice. There were serious deficits in respect of safeguarding at night time in the centre. Despite a daytime risk assessment relating to allegations and specific concerns being brought to the attention of the manager and director, common practice was that one staff member worked alone at night when others slept and often entered the room of one young person to support them. There was no associated risk assessment and practice in the centre was contrary to organisational policy. This practice was not safe for the young person or staff members but was explained in terms of financial constraints to inspectors. Furthermore, the records of waking nights were not adequate with many missing records and a lack of detail of interactions with young people. A waking night protocol provided to inspectors was not fit for purpose to ensure adequate safeguarding.

There was a risk assessment relating to agreed staffing ratios required for robust monitoring of the young people to ensure safe care however this was frequently not implemented in practice and is discussed further throughout this report.

Inspectors found very limited key working and individual work relating to supporting young people to develop self-awareness and skills needed to keep themselves safe in the community. This was highlighted during an external audit in July 2022 but remained an issue during this inspection and had not been addressed.

There was some evidence of communication with supervising social workers on a day-to-day basis by telephone as issues arose. However, social workers informed inspectors they did not receive copies of key planning documents such as placement plans, absence management plans, risk assessments, safety plans and weekly progress reports. All social workers acknowledged that the centre had experienced a difficult period with a changed group dynamic and that young people were negatively affected by this.

There was a written policy in place on protected disclosures. While staff interviewed were not familiar with the policy, they were able to identify people who they could bring a concern to if required. There were no reported protected disclosures since the last inspection however staff had raised valid concerns about safeguarding practice at night and also about staffing ratios. They should have considered reporting formally through the policy when they did not feel listened to or felt that appropriate action was not taken.

There was no evidence that external compliance audits were undertaken, to include Theme 3 (Safe Care and Support) of the National Standards for Children's Residential Centres, 2018 (HIQA). Therefore, the issues highlighted during inspection were not identified or addressed.

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

The centre had policies and procedures to guide the management of behaviour that challenged. These included, supporting positive behaviour, the use of consequences, risk assessment and the use of restrictive practices. There were also policies to guide staff practice relating to significant events and young people missing in care.
There was a formal warning system in place that was intended to be used when young people's behaviour was resistant to change. The procedure outlined consultation with social workers to support the placement and included a six-stage process that could culminate in a young person's discharge from the centre. This policy set out reasons that the warning system would be used, and this included possession of drugs or alcohol, behaviour that threatened the safety of others and persistent non-adherence to house rules. Inspectors found the centre did not adhere to this policy and procedure and question its purpose if not followed when the circumstances indicated it should have been.

Centre policies indicated that a range of documents were in place to support the management of behaviour. These included individual crisis support plans (ICSP) aligned to the model of behaviour management in use, risk assessments and safety plans, individual absence management plans (IAMP) and behaviour support plans (BSP). Implementation of these policies and practices were not evident during inspection.

Inspectors found that there had been a very difficult period in the centre since November 2022 and there were more than 130 significant events recorded and notified. Review of centre records indicated that there were other significant incidents that were neither recorded or notified as such. It was difficult for inspectors to determine that there was a positive approach to behaviour management as much of relevant information was not held on care files. While it was evident from interviews and some records that staff made efforts to use relationships to engage young people and were committed to them; this was negatively impacted by the lack of a consistent staff team and the centre's model of care could not be fully realised.

One young person expressed frustration to inspectors about the many staff changes. This is further discussed under standard 6.1 of this report.

Inspectors found that there had been frequent instances of young people being missing from care. However, they noted that *'Children Missing from Care: a Joint Protocol between An Garda Síochána and the Health Service Executive Children and Family Services'* was not implemented as intended and individual absence management plans were not followed for two young people. Inspectors found that this significantly increased risk from a safeguarding perspective. Young people did not meet the thresholds for the Joint Protocol Gardaí/Tusla meetings as they were not reported missing in care in line with their absence management plans.

Inspectors found that only three staff were appropriately trained in the model of behaviour management and the system could not be implemented in the centre as intended. None of the young people in the centre had a specific behaviour support plan in line with centre policy. The IAMPs in place were not aligned to *'Children Missing from Care: a Joint Protocol between An Garda Síochána and the Health Service Executive Children and Family Services'* and did not include curfews, places that young people were permitted and there was no reference to specific risks or vulnerabilities.

Inspectors found a lack of congruence between policy, staff understanding and practice in the centre relating to the model of behaviour management in place. The policy stated that *'behaviour that challenges may require a response that includes physical intervention by trained members of the centre's staff team'*. However, staff and management interviewed during inspection informed inspectors that the centre had a "*no restraint*" policy. Inspectors reviewed young people's ICSP documents and found that these also provided contradictory information. They were not signed by any member of management and did not provide clear guidance on actions to take if young people were a danger to themselves or others.

Some staff members and the social worker for one young person queried if restraint could be used in a therapeutic way to support them to keep young people, staff and the environment safe. However, they were informed by management that this was not possible. In addition, the staff team were not appropriately trained to use physical interventions if required – this was contrary to centre policy and placement proposals viewed during inspection. Training in the model of behaviour management that was due to take place in 2022 was postponed and still outstanding at the time of inspection due to financial constraints.

It should be noted that one young person was placed in the centre under derogation as they were under the age range for the purpose and function. Monthly child in care review meetings should have been convened; however, only one took place in the three months after admission with a care plan being provided to the centre following the review. Social workers and centre management explained that this was due to circumstances beyond their control. Monthly child in care review meetings must take place in line with the *National Policy in relation to the Placement of children aged 12 years and under in the Care or Custody of the Health Service Executive* and the derogation agreement to ensure effective planning.

Inspectors found that non routine physical interventions were used three times, once with each of the young people, however these were not appropriately recorded, notified or reviewed for learning purposes and there was no evidence of consultation and follow up with supervising social workers.
Upon review of young people's files inspectors found that a need for additional training was identified to support young people to manage behaviours of concern. This training was discussed at management and team meetings but was not provided in a timely manner. Social workers and a Guardian ad Litem who spoke to inspectors also identified significant delays in implementing training or approaches to behaviour management that had been discussed at planning meetings. There was a consultant child and adolescent psychotherapist attached to the company available to advise and guide the team. Brief records of these sessions were reviewed. Inspectors found there was a lack of evidence that the suggested interventions were being incorporated into young people's plans and that staff practices changed.

Inspectors found that young people's placement plans did not have a section pertaining to behaviour and so were not fully aligned to statutory care plans. This deficit was highlighted during a recent inspection of another service within this organisation. However, the learning was not communicated to ensure company-wide service improvements.

There was evidence that significant event review group meetings took place however they generally viewed incidents in isolation and did not effectively review them for trends or patterns. The minutes of meetings did not demonstrate a thorough analysis of all possible contributing factors such as training, consistent staffing, or adherence to centre policies. There was a lack of evidence that learning relating to how to prevent and manage challenging behaviour was communicated back to the team.

Some staff in interview with inspectors acknowledged the support of internal management in dealing with difficult behaviour on a daily basis. Notwithstanding this, supplementary staff not part of the core team said that they did not receive debriefing or extra supports even following assaults and they were not involved in team meetings or other planning meetings. They also informed inspectors that they were not provided with an induction when they began covering shifts in this centre.

Inspectors found that specialist supports were available or being sourced for each of the young people. One young person until recently had declined to engage in any of the supports on offer and had not made progress in respect of risk-taking behaviour. Planning relating to behaviour management for this young person was not proportionate to the level of risk and was not appropriately shared. From a review of records and speaking to the social work department, it was clear that they were not notified of all incidents or issues of concern and that notifications of significant events sometimes occurred up to five weeks after incidents. They could not therefore make an accurate assessment of risk or agree a specific programme of intervention to support the young person. This delay in notification of significant events was also highlighted by social workers for the other young people.

It is the finding of inspectors that risk was not appropriately assessed or managed, tracked, or escalated to ensure the provision of safe care and support. There was a policy governing risk management, however, staff in interview were unable to describe how it worked in operation and described differences of opinion as to levels of presenting risk. The risk management framework did not contain a scoring mechanism whereby upon review of risk, scores could be increased or decreased based on likelihood or probability to facilitate effective planning regarding behaviour management.

There was a policy document to guide the staff team in the use of restrictive practices at the centre. Inspectors found that staff understood what constituted a restrictive practice. Several restrictive practices were in place and recorded for all young people. These included practices such as CCTV outside the centre, room searches and locking parts of the house. Risk assessments determined the need for restrictive practices and there was some evidence of review at team and management meetings. However, there was no risk assessment relating to the impact of restrictive practices related to the behaviour of one young person and how these negatively impacted on the experience of the other young people. Inspectors found that most of their expressions of dissatisfaction were not recorded and managed in line with the complaints policy and they were not notified as significant to the supervising social work departments.

Inspectors found that no internal or external audits of behaviour management took place. Organisational oversight was lacking and mechanisms were not in place to adequately assess all aspects of behaviour management including adherence to the centre's own policy documents.

Compliance with Regulation	
Regulation met	**None identified**
Regulation not met	**Regulation 5** **Regulation 16**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 3.1** **Standard 3.2**

Actions required.

- The director of service must ensure that the policy document is updated to include deficits highlighted during this inspection and fully comply with relevant policies as outlined Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The director of service must ensure that compliance audits include Theme 3 (Safe Care and Support) of the National Standards for Children's Residential Centres, 2018 (HIQA).
- The director of service must ensure that all employees in the organisation are aware of the risks set out in the Child Safeguarding Statement (CSS). The statement must be updated to include the risk of child sexual exploitation and any potential risks associated with intimate care.
- The director of service must ensure there is an accurate list of mandated persons in the centre at all times.
- The director of service must ensure that all employees are fully aware of their responsibilities as mandated persons in relation to reporting child protection and welfare concerns.
- The director of service must ensure that potential bullying in the centre is assessed and managed in line with their own policies and procedures and monitored to assess if it meets reporting thresholds under Children First.
- The director of service must ensure that procedures in place for the prompt notification of significant events is adhered to at all times.

- The director of service must ensure that national policy relating to 'Children Missing from Care a Joint Protocol between An Garda Síochána and the Health Service Executive Children and Family Services is fully implemented in the centre.
- The director of service must ensure that all staff are aware of the Tusla Child Sexual Exploitation (CSE) reporting mechanism and associated checklist, and that it is implemented in practice in the centre.
- The director of service must ensure there is adequate oversight of reported child protection/welfare concerns and that there is accurate recording of child protection concerns that were determined not to meet the threshold for reporting under Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The director of service must consult with relevant social work departments and ensure that there is adequate safeguarding at night-time and in respect of intimate care of young people.
- The director of service must ensure that there are accurate records of waking nights in the centre.
- The director of service must ensure that there is evidence of key working and individual work to support young people develop self-awareness and skills needed to keep themselves safe in the community.
- The director of service must assure themselves that staff are aware of and confident to use the organisation's policy and procedure on protected disclosures.
- The director of service must ensure that there is oversight of implementation of all policies and procedures relating to behaviour management.
- The director of service must ensure that all relevant information is held on care files to facilitate effective planning.
- The director of service must ensure that all significant events are properly recorded and notified in line with regulations, national standards, and centre policies.
- The director of service must ensure that there is a review of the model of behaviour management and ensure full implementation of criteria set by the accrediting institution. There must be clarity in respect of the potential use of physical restraint to ensure safety.
- The director of service must ensure that all staff are fully trained in the model of behaviour management prior to working in the centre in line with their own organisational policies.
- The director of service and supervising social work department must ensure that monthly child in care review meetings take place in line with national

policy and the derogation agreement, where young people are under 13 years of age.

- The director of service must ensure that any non-routine physical interventions are appropriately recorded, notified and reviewed for learning purposes.
- The director of service must ensure that there are no delays in the provision of additional training by identified social workers, or clinical professionals.
- The director of service must ensure that young people's placement plans are aligned to their care plans and include a section pertaining to behaviour management.
- The director of service must ensure that significant event review mechanisms demonstrate a thorough analysis of all possible contributing factors, and that guidance relating to manage challenging behaviour is communicated back to the team.
- The director of service must ensure that adequate debriefing and extra supports are provided to any staff members dealing with extremely challenging behaviour or assaults.
- The director of service must ensure that all planning relating to behaviour management is proportionate to the level of risk and is appropriately assessed, managed, tracked and escalated to ensure the provision of safe care.
- The director of service must ensure that risk management framework is fit for purpose, fully understood and implemented in practice.
- The director of service must assess the impact of restrictive practices related to the behaviour of one young person and how these impact the experience of the other young people in the centre. This must be communicated to all social workers in a timely manner.
- The director of service must ensure that there is internal and external auditing of the centre's approach to managing behaviours that challenge.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

It was the assessment of inspectors that the centre was not currently being operated in compliance with the requirements of requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies and the National Standards for Children's Residential Centres, 2018 (HIQA). Further, there was little evidence that the safety, quality of care and support was reviewed to inform service and practice improvements. A review of team, management and organisational meetings did not demonstrate effective oversight of service delivery.

Inspectors found that this audit did highlight many areas that required improvement including: governance and oversight, management of records, key working deficits, significant event recording notification, and delays in updating planning documents amongst others. Inspectors found that all these areas still required remedial attention and had not been appropriately followed up by internal and senior management.

There was a self-auditing process in place which was aligned to national standards however, inspectors found that there was evidence of repetition and copy and paste from month to month. While the template was useful there were some deficits, and these audits did not demonstrate a thorough assessment and analysis of compliance with relevant regulations and national standards. For example, child protection was not included in these audits. In addition, inspectors found that fire safety was not adequately reported through this audit process. Inspectors found serious deficits in respect of fire safety that resulted in an immediate action notice requiring the provider to take urgent remedial action. The fire register had highlighted problems with the functioning of fire doors for more than 12 months, yet it was not reported through the auditing process. The fire register was not completed properly as daily, weekly, quarterly, and annual checks were not reported or were delayed.
The arrangements in place for external auditing of assessment of the safety and quality of care against national standards was inadequate, was not fit for purpose to effectively analyse compliance and facilitate service improvements. The last audit took place in July 2022 and a follow up action plan was completed. This audit reviewed care files, registers, daily administration and health and safety. It must be noted that the serious fire safety issues that were highlighted during this inspection were not highlighted as part of the review of health and safety. There were no external audits or quality assurance checks in place and there was an was unacceptable lack of oversight over compliance with fire safety requirements.

It was the assessment of inspectors that the recording, responses, monitoring and analysis of significant events and complaints was inadequate as described above

under previous standards. There was no dedicated handover time to facilitate the transfer of key information from shift to shift and staff had to remain on past the end of their paid shifts. In addition, young people's care files were not maintained and organised to facilitate planning for safe and effective care and these issues were not highlighted through effective governance mechanisms.

Inspectors found that there was a delay in removing access to emails and previous correspondence for staff members who left the organisation. These staff members had access to a company email address on their personal phones. This must be reviewed as a matter of priority to ensure that no personal or sensitive information was accessible to people no longer working there. Any breaches must be immediately reported to the data commissioner.

Safety of care was compromised also when agreed staffing (based on risk assessments in consultation with the Tusla National Private Placement Team and the supervising social work department) could not be implemented on an ongoing basis. There was evidence that this was brought to senior management attention however it was not escalated to the other parties for their agreement. Social workers and Guardians ad Litem who spoke with inspectors were not aware that the staffing ratios were below agreed levels to care for young people.

The manager of the service received external professional supervision and there was a written agreement in place that issues arising would be brought to the attention of the Director of Service. The manager did not sign or receive copies of their supervision sessions. Inspectors reviewed copies of feedback from the external supervisor to the director with a summary of themes arising during managers supervision. These included issues such as management support and development, the need to have clearly defined roles and responsibilities, the need for clear boundaries between the managers and the director's role, training, staff turnover and staff selection process. There was no evidence that these issues were followed up with managers or formed part of strategic organisational development.

Inspectors found that many of the deficits in respect of quality and safety of care were explained by the registered provider in the context of financial constraints and they had not conducted annual reviews of compliance with the centre's objectives in either 2021 or 2022 as required by the national standards.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 5.3**

Actions required.

- The director of service must ensure that there is evidence that the safety, quality of care and support is regularly reviewed to inform service and practice improvements.
- The director of service must ensure that the arrangements in place for external auditing of assessment of the safety and quality of care against national standards is fit for purpose. They must ensure that any identified remedial actions are implemented without delay.
- The director of service must ensure that when safety of care is compromised for any reason that this is communicate to all relevant professionals without delay.
- The director of service must ensure that there is robust oversight over compliance with fire safety requirements at all times.
- The director of service must ensure that there is no access to emails and previous correspondence for any staff members who left the organisation. A review must take place to ensure that no data breached have happened to date.
- The director of service must ensure that the system for the recording, responding, monitoring, and analysing complaints is fit for purpose.
- The director of service must ensure that annual reviews of compliance with the centre's objectives are conducted in a timely manner to inform service improvements.

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 evidence that while workforce planning was discussed at management and organisational meetings it was generally in the context of gaps in particular services and not from an organisational perspective with definitive actions and strategic planning.

There were not appropriate numbers of staff employed with regard to the number and needs of the young people. As previously discussed, there was an agreement based on risk assessment and safety planning that four staff were required on shift each day and that there would be two sleeping and one waking night staff on duty. A minimum of 12 staff was required to implement this staffing ratio. At the time of inspection there was a staffing complement of 7.75 WTE staff which was below the core number required for normal operation of the service even prior to the need for extra staffing. Inspectors found from speaking with one young person and review of centre records that large numbers of staff had covered shifts in the centre and that young people experienced an inconsistent team with some people working in the centre who were not known to them at all. Not all complaints relating to this were managed in line with centre policy. The centre was relying on staff from another centre in the organisation that had no young people living there, as well as some agency staff. In addition, there were occasions where managers and the Director had to cover shifts in the centre. Social workers and other professional were not aware that the agreed ratio was not in place.

Five new staff were appointed to the centre since October 2022 and most had no previous experience of working in residential care. Given the complex needs of the young people and the lack of training and induction, inspectors found that while the team were committed to the young people, they did not have the experience and competencies to meet the needs of the young people at that time. Also, inspectors found that some staff had been promoted to (or were interviewed for) roles that they did not hold the required experience for.

Information was provided to inspectors that there were three relief staff available. However, it was often the case that annual leave, sick leave and other types of leave could not be covered, and the centre was below the agreed staffing ratio with only two or three staff available in many instances rather then 4:3 ratio that was risk assessed and agreed. More concerning was that inspectors found several occasions that dedicated waking night staff were not available and that this was covered by staff on their normal 24-hour shift. Some staff stated in interview that they stayed awake while others said they slept outside a young person's room and woke to support them if they were called.

It was not possible from review of management and organisational records to determine what measures are in place to promote staff retention to ensure stability for young people.
Staff had expressed numerous concerns during inspection interviews. This along with a review of centre records pointed to low morale , poor induction and a lack of training and development of the team to best meet the needs of the children.

There were formalised procedures in place for on call at evenings and weekends.

Standard 6.2 The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

Inspectors found there were serious deficits with regard to recruitment and vetting of staff and the maintenance of up to date, accurate personnel files. Inspection findings included the following:

- Staff personnel files did not contain an appropriate record of the interview process (by at least two people) and evidence of suitability for the position being applied for.
- In some instances, a full employment and education history, in the form of an up to date CV, to assess gaps in employment and education was not available.
- Details and documentary evidence of relevant qualifications including verification of the qualification from the awarding institution was not available on some staff files.
- Staff personnel files did not contain job descriptions or signed contracts.
- In some instances, references were historical documents that prospective employees had in their possession and were not specifically obtained for this employment.

- In some instances, references were provided from people that were peers or colleagues who were not in a position of line management for the prospective employee. In other instances, the role of the referee was not clear on the document.
- A comprehensive record of training and continuous professional development undertaken by the staff member including certificates was not available.
- Where a conviction was recorded, a risk assessment conducted by the registered provider that assesses the suitability of the employee to work with children and young people was not available.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 6.1** **Standard 6.2**

Actions required.

- The director of service must ensure that there is evidence of workforce planning from an organisational perspective with definitive actions and strategic planning.
- The director of service must ensure that there are appropriate numbers of staff employed with regard to the number and needs of young people and staffing ratios agreed with the funding body and supervising social work departments.
- The director of service must ensure that agreed dedicated waking night staff are in place at all times.
- The director of service must ensure that the staff team have the training, experience and competencies and supports to meet the needs of the young people.
- The director of service must ensure that there is evidence that the various issues contributing to low team morale and staff retention are explored and addressed to ensure stability and consistency for young people.
- The director of service must ensure that there is a robust recruitment and selection process that adheres to organisational policies and procedures and

Children First: National Guidance for the Protection and Welfare of Children, 2017

- The director of service must there is maintenance and oversight of up to date, accurate personnel files.

3. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3.1	The director of service must ensure that the policy document is updated to include deficits highlighted during this inspection and fully comply with relevant policies as outlined Children First: National Guidance for the Protection and Welfare of Children, 2017.	Policies and procedures to be updated to reflect findings in recent inspection. This will be undertaken by the manager of the centre and director by June 30th 2023.	P&P to be reviewed yearly and after each subsequent inspection to include recommendations.
	The director of service must ensure that compliance audits include Theme 3 (Safe Care and Support) of the National Standards for Children's Residential Centres, 2018 (HIQA).	Weekly auditing to encompass theme 3 as directed. This is in place.	External auding to provide oversight of internal director/manager audits to ensure all themes are reflected in the procedure.
	The director of service must ensure that there is a robust recruitment and selection process that adheres to organisational policies and procedures and Children First: National Guidance for the Protection and Welfare of	The recruitment policy will be revised and updated by the director/manager. To be complete by June 30th 2023.	External auditing service to review recruitment processes in quarterly audits to confirm strict adherence to the organisational policy. Weekly auditing by director to include recruitment and personnel files.

	Children, 2017		
	The director of service must there is maintenance and oversight of up to date, accurate personnel files.	Weekly audits to include personnel files.	External auditing to include examination of personnel files.
	The director of service must ensure that all employees in the organisation are aware of the risks set out in the Child Safeguarding Statement (CSS). The statement must be updated to include the risk of child sexual exploitation and any potential risks associated with intimate care.	CSS has been added to the biweekly staff meeting agenda for consistent revision with staff. The CSS has recently been submitted and approved by the compliance unit.	Director to discuss CSS with staff in informal weekly meetings to ascertain competence/issues with knowledge which can then be addressed by the manager with supervision/training plan.
	The director of service must ensure there is an accurate list of mandated persons in the centre at all times.	In place.	Director to check this is updated in line with current staffing in weekly audits.
	The director of service must ensure that all employees are fully aware of their responsibilities as mandated persons in relation to reporting child protection and welfare concerns.	External CP training complete with all staff. All etraining complete and certification on file. This has been added to the biweekly staff meeting as a standing agenda.	Director to discuss child protection with staff in informal weekly meetings to ascertain competence/issues with knowledge which can then be addressed by the manager with supervision/training plan.

	The director of service must ensure that potential bullying in the centre is assessed and managed in line with their own policies and procedures and monitored to assess if it meets reporting thresholds under Children First.	This centre is ceasing operation in June/July 2023.	
	The director of service must ensure that the procedure in place for the prompt notification of significant events is adhered to at all times.	All SENS are reported within 24 hours. Reports to be subject to weekly auditing including reporting times to highlight any issues going forward.	External and internal audits to check that every SEN is reported within the specified timeframe of 24 hours. Monthly SERG meeting to record oversight and discussion by management team of reporting timeframes monthly.
	The director of service must ensure that national policy relating to 'Children Missing from Care a Joint Protocol between An Garda Síochána and the Health Service Executive Children and Family Services is fully implemented in the centre.	In place. Discussed with staff in team meeting. In house training to be undertaken with staff May 2023.	Director to discuss with staff in informal weekly meetings to ascertain competence/issues with knowledge which can then be addressed by the manager with supervision/training plan.

	The director of service must ensure that all staff are aware of the Tusla Child Sexual Exploitation (CSE) reporting mechanism and associated checklist and that it is implemented in practice in the centre.	To be added to the training plan for May with missing from care protocol.	Director to discuss with staff in informal weekly meetings to ascertain competence/issues with knowledge which can then be addressed by the manager with supervision/training plan.
	The director of service must ensure there is adequate oversight of reported child protection/welfare concerns and that there is accurate recording of child protection concerns that were determined not to meet the threshold for reporting under Children First: National Guidance for the Protection and Welfare of Children, 2017.	Child protection and welfare concerns to be addressed weekly as part of internal auditing. This includes discussion with house manager to ascertain if any incidents meet the threshold for reporting or recording unmandated concerns. Discussion with management team at monthly meetings and biweekly at staff meetings also as a standing agenda. Weekly auditing to confirm follow up and conclusion of all reports on file.	Daily handover from manager and evaluation of daily records by director to determine if any CPWRFs are necessary. weekly auditing to oversee CP procedures. External audits to further safeguard the process.
	The director of service must consult with relevant social work departments and ensure that there is adequate safeguarding at night time and in	This young person is no longer in the unit. Unit to close June/July 2023.	

	respect of intimate care of young people. The director of service must ensure that there are accurate records of waking nights in the centre. The director of service must ensure that there is evidence of key working and individual work to support young people develop self-awareness and skills needed to keep themselves safe in the community. The director of service must assure themselves that staff are aware of and confident to use the organisation's policy and procedure on protected disclosures.	No waking night cover in place currently. All individual/keywork planned monthly and undertaken and recorded by staff/manager. Keywork file in place and subject to internal/external auditing. This has been added as a standing agenda to biweekly staff meetings.	Weekly auditing to evidence direct work with the young person. Director to discuss protected disclosure procedure with staff in informal weekly meetings to ascertain competence/issues with knowledge which can then be addressed by the manager with supervision/training plan.
3.2	The director of service must ensure that there is oversight of implementation of	Behaviour management and related records subject to weekly audits.	Internal/external auding to assess P&P relating to behaviour management with the

	all policies and procedures relating to behaviour management.	Daily discussion with director/manager/team to address issues and implement supports for the staff and YP. Biweekly psychotherapy support for the staff team in place. Monthly multidisciplinary meeting in place with professionals involved in YP care. Behaviour management is on this agenda.	aforementioned supports for this process in place.
	The director of service must ensure that all relevant information is held on care files to facilitate effective planning.	All information relevant to the effective running of the centre is printed and recorded on the care files. Daily handover sheets facilitate effective daily planning for the care of the YP.	Weekly auditing to assess care files to ascertain if all are being kept up to date and relevant with printed and signed documents in situ.
	The director of service must ensure that all significant events are properly recorded and notified in line with regulations, national standards, and centre policies.	All SENS are reported within the 24 hour timeframe.	Weekly auditing supported by external auditing to check this procedure is being stringently adhered to.

	The director of service must ensure that there is a review of the model of behaviour management and ensure full implementation of criteria set by the accrediting institution. There must be clarity in respect of the potential use of physical restraint to ensure safety.	Team member recently completed TCI trainer accreditation so we have an inhouse trainer to complete the behaviour management programme with staff. Use of physical restraint added for discussion to biweekly staff meeting.	Review of TCI training inhouse to be undertaken in monthly management meeting with TCI trainer as part of SERG.
	The director of service must ensure that all staff are fully trained in the model of behaviour management prior to working in the centre in line with their own organisational policies.	Inhouse trainer now in place and plan for training for the remainder of 2023 actioned. New staff to be trained before commencing work.	
	The director of service and supervising social work department must ensure that monthly child in care review meetings take place in line with national policy and the derogation agreement, where young people are under 13 years of age.	YP no longer in placement. Unit to close in June/July 2023.	
	The director of service must ensure that any non-routine physical interventions	Practice being undertaken in the unit with oversight of manager/director/TCI trainer.	Monthly SERG meetings to discuss the potential use of non routine physical

	are appropriately recorded, notified and reviewed for learning purposes.		interventions and manger to action as requested. Weekly auding of SENS/logs by director to identify any deficits in this regard.
	The director of service must ensure that there are no delays in the provision of additional training by identified social workers, or clinical professionals.	Training needs assessment undertaken monthly to identify deficits and/or beneficial training for staff. Every effort is made to provide this training in a timely manner.	Auditing of training logs internally/externally and of training needs analysis's to identify any deficits in mandatory/elective training for staff.
	The director of service must ensure that young people's placement plans are aligned to their care plans and include a section pertaining to behaviour management.	In place.	Placement plans/care plans subject to weekly auditing plan.
	The director of service must ensure that significant event review mechanisms demonstrate a thorough analysis of all possible contributing factors, and that guidance relating to manage challenging behaviour is communicated back to the team.	SERG meetings in place monthly as part of management meeting structure. All findings are communicated to the team in staff meeting thereafter.	Auding of SEN log weekly to consider the thorough analysis of all aspects of the incident and check correlating documents to provide oversight of the required process.

	The director of service must ensure that adequate debriefing and extra supports are provided to any staff members dealing with extremely challenging behaviour or assaults.	This is in place. Additional supervision offered to all staff experiencing challenges in the work. External supports/counselling are also available to all staff requesting such.	
	The director of service must ensure that all planning relating to behaviour management is proportionate to the level of risk and is appropriately assessed, managed, tracked and escalated to ensure the provision of safe care.	Risk management procedures in place in the unit. Overseen by the director and subject to external auditing. Risk management discussed in monthly professionals meeting also so that there is a collaborative approach to managing risk in the unit.	
	The director of service must ensure that risk management framework is fit for purpose, fully understood and implemented in practice.	Framework had recently been simplified to make it more user friendly for staff. To be discussed at management meeting May 2023 and training plan for risk management to be identified and actioned by June 30th 2023.	Risk management discussed at all level of the organisation and with related professionals to ensure safeguards are in place to attempt to mitigate any risk to the child. Auditing of the centre includes the areas of behaviour and risk management.

	The director of service must assess the impact of restrictive practices related to the behaviour of one young person and how these impact the experience of the other young people in the centre. This must be communicated to all social workers in a timely manner. The director of service must ensure that there is internal and external auditing of the centre's approach to managing behaviours that challenge	YP no longer in placement. Unit to close June/July 2023. Weekly internal auditing in place. External quarterly auditing in place.	
5	The director of service must ensure that there is evidence that the safety, quality of care and support is regularly reviewed to inform service and practice improvements. The director of service must ensure that the arrangements in place for external auditing of assessment of the safety and quality of care against national standards is fit for purpose. They must	Weekly recorded auditing in place to provide evidence of oversight and actioning of identified deficits. External auditing plan for quarterly auditing in place with private company.	External auditing to provide additional safeguards to internal procedures to identify issues with quality of care.

	ensure that any identified remedial actions are implemented without delay.		
	The director of service must ensure that when safety of care is compromised for any reason that this is communicate to all relevant professionals without delay.	Young person to which this applies is no longer with the service. Unit to close June/July 2023.	
	The director of service must ensure that there is robust oversight over compliance with fire safety requirements at all times.	Fire safety subject to weekly auditing. Service plan in place with external company to service and certify the fire system regularly. Fire doors to be checked by contractor every 6 months or if an issue is detected on a daily check. Daily update of health and safety procedures now includes additional fire safety checks.	Daily/weekly checks by manager/ director in relation to fire compliance in place. Contractors employed to service/maintain the systems in place.
	The director of service must ensure that there is no access to emails and previous correspondence for any staff members who left the organisation. A review must take place to ensure that no data breaches have happened to date.	Staff only have access to a personal KGRS email. They do not have access to company email accounts and only receive correspondence relating to inconsequential information such as staff meeting times etc. They cannot access sensitive information	

		through personal KGRS accounts. Accounts are deleted when staff cease employment.	
	The director of service must ensure that the system for the recording, responding, monitoring and analysing complaints is fit for purpose.	Complaints recording system updated. Complaints discussed and analysed at monthly management meeting and staff meetings biweekly.	Complaints are part of weekly auditing process and subject to examination by external auditors quarterly.
	The director of service must ensure that annual reviews of compliance with the centre's objectives are conducted in a timely manner to inform service improvements.	New auditing schedule to aid end of year compliance review in December 2023.	
6	The director of service must ensure that there is evidence of workforce planning from an organisational perspective with definitive actions and strategic planning.	Monthly organisational meetings encompass workforce planning for the centre.	
	The director of service must ensure that there are appropriate numbers of staff	Staffing levels currently sufficient to meet the needs of one YP in placement.	

	employed with regard to the number and needs of young people and staffing ratios agreed with the funding body and supervising social work departments.		
	The director of service must ensure that agreed dedicated waking night staff are in place at all times.	We no longer operate a waking night in this unit.	
	The director of service must ensure that the staff team have the training, experience and competencies and supports to meet the needs of the young people.	Staff team in single occupancy have been in situ since last inspection and are experienced and equipped to deal with the presenting needs of the YP in placement.	
	The director of service must ensure that there is evidence that the various issues contributing to low team morale and staff retention are explored and addressed to ensure stability and consistency for young people.	Recent changes made to staff renumeration package including wellness supports. Discussion and agreement to be reached with staff by June 30th 2023 regarding their preferred benefits and company supports.	