An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 037

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced Inspection**
Date of inspection:	**26th & 27th September 2023**
Registration Status:	**Registered from the 16th September 2022 to the 16th September 2025**
Inspection Team:	**Joanne Cogley** **Sinead Tierney**
Date Report Issued:	**1st December 2023**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 16th September 2010. At the time of this inspection the centre was in its fourth registration and in year three of the cycle. The centre was registered without attached conditions from 16th September 2022 to the 16th September 2025.

The centre was registered as a multi-occupancy centre that could accommodate four young people from age thirteen to seventeen on admission. The centre's model of care was based on a systemic therapeutic engagement model (STEM) and provides a framework for positive interventions. STEM draws on a number of complementary philosophies and approaches including circle of courage, response ability pathways, therapeutic crisis intervention and daily life events. There was one young person living in the centre at the time of the inspection. They were placed outside of the centre's purpose and function and a derogation had been approved from the Alternative Care Inspection and Monitoring Service.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.2
4: Health, Wellbeing and Development	4.2
5: Leadership, Governance and Management	5.4

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 11th October 2023 and to the relevant social work departments on the 11th October 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 suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 25th October. This was deemed to be unsatisfactory and was returned to the centre manager for further review. An updated CAPA was received on the 10th November 2023 and this was deemed 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: 037 without attached conditions from the 16th September 2022 to the 16th September 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

The organisation had policies in place to support a positive approach to behaviour management. Inspectors reviewed a number of significant event notifications (SEN's) and consequence records and found evidence that positive rewards were in place along with the reporting of positive significant events. It was noted despite a high level of incidents, there did not appear to be an over-reliance on the use of restraint, nor an over-reliance on the use of negative consequences to behaviours.

Inspectors reviewed training certificates and found all bar two staff were trained in a recognised model of behaviour management. The two untrained staff members were booked to attend a course two weeks post inspection and did not appear to have been involved in any physical interventions. From a review of sample SEN's inspectors noted that a number of physical interventions could not be maintained properly when initiated which resulted in the young person biting and headbutting staff members. It was also evident there was a lack of recording in relation to how some physical interventions were carried out and there was a lack of recording of non-routine physical interventions. These incidents had not been reviewed or analysed by the centre manager or senior management and a review of physical intervention should occur.

The young person was supported by three staff daily however it was noted that the third staff was utilised as a support to the team as opposed to the young person. They mainly focused on operational tasks within the house and at times were supporting the young person and other team members with the management incidents within the centre. The allocated social worker was of the opinion the third staff was to be utilised for crisis management. It was evident from review of significant event notifications that at times of distress both the young person and staff team would benefit from the support of a third person, in particular during serious incidents occurring within the car. The third person was not always present. There was no

clear guidance as to the purpose of the third staff member and this should be agreed and outlined for all professionals working with the young person.

Staff interviewed demonstrated knowledge and skills appropriate to their role. They were supported in their role by a Tusla Psychologist who they met with on a fortnightly basis to discuss approaches utilised with the young person. The psychologist had provided the team with an 'emotion regulation support plan' and plans to support the young person's sensory system. It was evident from a review of paperwork, these support plans translated through into the team's daily work with the young person. There was evidence to show they were actively reviewed and adjusted in the fortnightly meetings that occurred. Inspectors spoke with the psychologist who noted the team were very open to the guidance provided and were open to reflecting on their work and approaches and altering them where needed. The psychologist noted that the young person had made several attempts to divide and conquer within the team but that the team members worked consistently as a unit which in their opinion has resulted in the young person starting to feel safe and secure within their placement.

Inspectors reviewed individual work records and found that a high standard of key working had occurred with the young person across areas of bullying, racism, toxic social media figures, road safety and understanding their own behaviours.

There was evidence of restrictive practice in place at the time of inspection. These were appropriately risk assessed. Whilst it was part of the standing item agenda at team meetings, the recording of discussion did not allow inspectors to make a determination that the risk assessments were being actively reviewed. Appropriate evidence of review of restrictive practice should be demonstrated.

A behaviour management audit had been carried out by an auditor external to the organisation in September 2023. The methodology for this audit was not outlined nor did it appear that the auditor met with staff or the young person to form robust findings. Areas for improvement were identified however inspectors did not find that the audit correlated with the findings of this inspection for example; safety risks related to physical interventions, inappropriate scoring of risks. Auditing will be discussed further under standard 5.4 of this report.

At the time of inspection there was one young person in placement for a period of four months. They had struggled with settling into their placement and were involved in seventy-two significant events. Due to the high level of risk associated

with the significant event notifications, the centre made a decision to issue notice of discharge in July 2023 but were continuing to work with the social work department until a more suitable placement was available or adequate resources and supports were provided to the staff team working with the young person, reviewing discharge notice on a regular basis. All involved in the young persons care agreed the discharge notice made it difficult to plan long term for the young person and it would be in their best interest that a decision could be made in the near future. The Tusla allocated Psychologist and Social Worker were of the opinion the placement was meeting the young persons needs and could see small steps in progress in the short time the young person was in the placement.

Compliance with Regulation	
Regulation met /not met	**Regulation 5** **Regulation 16**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Standard 3.2**
Practices did not meet the required standard	**Not all standards were assessed**

Actions required:

- The regional manager and centre manager must ensure a full review of physical intervention occurs and learning shared with team members and professionals.
- The regional manager and centre manager must ensure there are clear guidelines as to the purpose of the third staff member.
- The centre manager must ensure appropriate evidence of review of restrictive practice is demonstrated.

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.

The young person was four months in placement and whilst statutory reviews were occurring, despite requests, the centre was yet to receive an up-to-date care plan or statutory minutes from the social work department. In the absence of a care plan the centre had developed their own placement plan that accounted for the young persons health needs. The centre had received social history reports along with assessments and immunisation records upon admission. Significant supports were required for the young person and the social work department had responsibility for ensuring referrals to appropriate services occurred. Inspectors spoke with the allocated social worker who informed them progress had been made in relation to a number of referrals with appointments scheduled for later in October 2023. The young person had an allocated general practitioner (GP) which was a family GP. They had also attended a number of dental appointments and follow up appointments had been scheduled.

There was a specific health concern associated with the young person at the time of inspection. The team were working with an allocated psychologist to explore root causes and were also completing individual work with the young person to gain their insight. The psychologist highlighted to inspectors an important aspect of approaching this concern with the young person was through a non-judgemental approach which meant relationship building was integral. They were of the opinion strong relationships were in the process of being formed. A referral had been made by the social worker to a medical specialist and an appointment had been set for the 3rd week in October. Whilst the staff team were working with the psychologist on the childcare approach to managing this concern, inspectors did not see evidence of clear written guidelines in place to support staff to manage the health and safety aspect of the concern. Staff members that spoke with inspectors also raised concerns in relation to their lack of understanding of the behaviour and stated they would benefit from further specialist training in this area, and this should be sourced for the team as a matter of priority.

A medication management policy was in place and staff had received training in the safe administration of medication.

Compliance with Regulation	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**Not all standards were assessed**

Actions required:

- The centre manager must ensure written guidelines are in place for staff to support them to manage specific health and safety concerns and the regional manager must ensure appropriate training is provided to the team.

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.

A number of inspections had occurred in centres within the organisation in the year prior. Inspectors noted, from review of paperwork and through interviews that learning from these inspections had not translated into practice within the centre, with the manager unaware of some aspects of recommendations. Identical issues arose during this inspection such as damage to fire doors and deficits in the understanding of complaints and child protection.

The organisation had recently updated the complaints policy and template to reflect actions identified in previous inspections within the organisation. It was found however that whilst these improvements had been made, staff and management remained unclear about what constituted a 'notifiable' complaint and referred to child protection concerns being reported under the complaints process. Some

complaints were noted on file that had been recorded as non-notifiable and responded to through individual work sessions however it is the opinion of inspectors these were wrongly classified. Complaints relating to living within the centre, feeling unsafe in the centre, social work departments and family access should not be investigated by the centre in the interest of transparency and should be reported as notifiable complaints through appropriate avenues for investigation.

There was oversight of significant events by the centre manager however oversight from senior management was limited. Inspectors noted the oversight evident did not address some issues that had arisen during incidents such as difficulty maintaining physical holds and the young person stating they felt unsafe in the centre. A significant event review (SERG) report was completed on a monthly basis and informed a management SERG meeting. Team members confirmed they did not have access to this report. While the report contains good, relevant data, it is important those working with the young person on daily basis have access to this report to support their learning and development. Whilst a risk management framework was in place, inspectors found that several risk ratings were particularly low given the safety concerns for the young person. When compared to other risks assessed within the unit that were lower-level risks, inspectors found low and high level risks received the same risk rating. Again, these areas were previously identified as part of inspections in the organisation, yet practice in this centre was not in line with learning identified.

An annual review of compliance for 2022 had been completed by the registered providers. This was in line with the national standards and outlined improvements and actions required within the centre. Inspectors noted from review not all areas identified had been actioned and followed through on, such as quarterly themed audits not occurring, regional manager feedback on significant events not robust and a risk audit to assess scoring hadn't occurred.

Regular assessments of the safety and quality of care were not aligned with the National Standards for Children's Residential Centres. The regional manager had undertaken a review of medication management, key and safes, car safety and health & safety. They had also undertaken a review of complaints and child protection in early 2023 prior to the current resident living in the centre.

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

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Not all standards were assessed**
Practices did not meet the required standard	**Standard 5.4**

Actions required:

- The regional manager must ensure that a clear plan to support the team in their knowledge, understanding and implementation of the complaint policy and procedure.
- The registered provider must ensure that the arrangements in place to assess the safety and quality of care provided against the National Standards are robust alongside effective mechanism for sharing learning across the organisation.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The regional manager and centre manager must ensure a full review of physical intervention occurs and learning shared with team members and professionals.	Regional Manager and Centre Manager reviewed SEN's which involved physical restraints on 10.10.2023. Physical restraint review was completed onsite with the team on 12.10.2023 by Associate TCI trainer which included review and practicing of appropriate restraints. Learning and changes to approach were shared with multidisciplinary team at professionals meeting on 18.10.2023.	Centre Manager will ensure that staff utilise adjusted small child restraint or seated restraint when required. Restraints and their efficiency will be reviewed in team meetings and documented in team meeting minutes. Furthermore, a quarterly review will be carried out and discussed at regional SERG meetings.
	The regional manager and centre manager must ensure there are clear guidelines as to the purpose of the third staff member and the funding body is informed when a third staff member in unavailable.	The purpose of the third staff member will continue to be as a support person to the two overnight staff on shift and the young person. Typical duties include provision of additional breaks, required paperwork, and support with household duties. Centre Manager and Deputy Manager will	Management meetings will monitor the utilisation of third staff member. Social Care Manager will make sure that third staff members are scheduled on daily.

	The centre manager must ensure appropriate evidence of review of restrictive practice is demonstrated.	monitor duties assigned to third staff members during handover. The funding body will continue to be informed in cases where the centre experience challenges in deploying a third staff member to the floor. A review of restrictive practices will be completed by centre manager by 20.10.23. Restrictive practices will continue to be reviewed at team meetings and the recording of same with be expanded upon.	Restrictive practices are reviewed at team meetings are also recorded in centre monthly reports and reviewed by Regional Manager and Quality Assurance Manager.
4	The centre manager must ensure written guidelines are in place for staff to support them to manage specific health and safety concerns and the regional manager must ensure appropriate training is provided to the team.	Risk assessments have been reviewed and training specific to young person's needs was completed 17.10.23 and further has been organised for 21.11.23.	Centre Manager will ensure that written guidelines regarding Health and Safety is updated regularly, and that Health and Safety issues are regularly reviewed in management and team meetings recording the discussions in the relevant Meeting Minutes.
5	The regional manager must ensure that a clear plan to support the team in their knowledge, understanding and	Complaint policy was reviewed with the team on 25.10.2023 by Quality Assurance Manager. In advance of this, all team	Complaints Audit will be completed by Regional Manager on complaints in November 2023, inclusive of staff

	implementation of the complaint policy and procedure.	members were requested to complete the online resource 'Guide to Responding to Complaints' allowing for greater focus at the Team Meeting, including guidance for escalating complaints externally to the centre where local resolution do not resolve the complaint or where required as per policy. Complaints policy and procedure will be covered as part of a staff member's induction journey. Implemented from 6th November 2023 Regional Manager will complete a complaint audit, inclusive of staff interview in November 2023 and again in March 2023.	knowledge on the complaints policy and procedure. Action plan will be completed and shared with Centre Management team and presented at team meeting and supervision where appropriate. A further complaint audit will be completed in March 2024, which will also include staff interview to determine knowledge. The Complaints Audit will be reviewed in November to allow for further demonstration of staff knowledge, understanding, and implementation of the complaints policy and procedure. This audit will be carried out twice per annum.
	The registered provider must ensure that the arrangements in place to assess the safety and quality of care provided against the National Standards are robust alongside effective mechanism for sharing learning across the organisation.	Regional Manager will complete a complaints audit in November 2023 and continue with scheduled themed audits over the next 12 months. Quarterly Inspection Report Review meetings with Quality Assurance team and Director of Services will inform sharing of	Senior Management themed audits will continue to be completed, with regular feedback and action plans to be provided to Centre Manager. Regional management meetings will be used to ensure learning is applied across all centres. Our audits are thematic and capture

		learning across the organisation. Learning from inspections will continue to be discussed at Senior Management Meetings and where changes to policies or processes are required, these will be scheduled, and communicated. The quality assurance team will review its current recording systems to ensure that there is evidence available to support these activities and to demonstrate scheduling, oversight and direction, and ensure that this revision is in place in January 2024. Our audits are thematic and capture multiple National Standards when completed. The senior management team will review the current audits in place with the goal of highlighting the particular National Standard being explored at that time. This will be completed in November and will be in effect January 1st 2024.	multiple National Standards when completed. The senior management team will review the current audits in place with the goal of highlighting the particular National Standard being explored. This will be completed in November and will be in effect January 1st 2024. The senior management team and Quality Assurance Manager will review existing audits such as risk assessment and will ensure that areas of focus are aligned with particular National Standards under review. This work will be completed and implemented in January 2024.