An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 042

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Misty Croft**
Registered Capacity:	**Registered for six young people**
Type of Inspection:	**Announced**
Date of inspection:	**24th, 25th May & 1st June 2022**
Registration Status:	**Registered from 17th July 2021 to 17th July 2024**
Inspection Team:	**Lisa Tobin** **Sharon McLoughlin**
Date Report Issued:	**7th September 2022**

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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 17th July 2009. At the time of this inspection the centre was in its fifth registration and was in year one of the cycle. The centre was registered without attached conditions from 17th July 2021 to 17th July 2024.

The centre was registered as a multi-occupancy service. It aimed to provide a placement for young people aged from twelve to seventeen years on admission suitable to be placed on an emergency, short term, medium term or respite basis. Referrals were accepted from Tusla's social work team for Separated Children Seeking International Protection, Tusla's National Private Placement Team and the out of hours' social work department. The model of care was underpinned by a Maslow's hierarchy of needs and the purpose was to meet the primary, individualised needs of young people through a person-centred approach with the aim of supporting integration. It was described as needs led, child centred care with a focus on care, health, integration, education and independence. There were six young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 28th July 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 24th August 2022. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 042 without attached conditions from the 17th July 2021 to 17th July 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 1: Child-centred Care and Support

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

Inspectors reviewed documentation which showed young people were informed about their rights, the complaints process and what to expect during their placement in the centre when they had their admission meeting and in the days after their admission. The young people were supported by their keyworkers and by interpreters as needed for this process. The inspectors noted that the young people's voice was captured in different ways; during young people's meetings, in their placement plans which had a specific area for recording the young person's voice, through the informal/formal complaints process and during key working and individual work. Through reviewing the questionnaires of the young people, inspectors saw that the young people felt listened to and that they liked where they lived. The young people stated that they were able to identify someone they could speak with if they had an issue or concern.

Given the nature of the placements and the unknown backgrounds of the young people that presented to the centre, staff created a safe environment for the young people from their initial arrival. The staff's awareness of the potential trauma endured by the young people was captured in the key working and individual work completed with them addressing their rights and about how to keep themselves safe while in the placement. Inspectors noted that these topics of rights and complaints was discussed regularly with the young people along with an openness to support the young people should they wish to discuss any information from their past or present. While reviewing the weekly young people's meeting, inspectors saw there was a space for each young person to acknowledge how their week went, what activities and meals they planned for the coming week, any concerns they wanted to raise relating to the centre and then time for discussion around topics such as rights, health and wellbeing, staying safe, curfews, complaints and the National Standards for Children's Residential Centres, 2018 (HIQA) to name a few. The sample minutes reviewed showed that the young people attended and participated in those meetings.

The young people's meeting minutes were then discussed at the team meeting and plans were adapted based on the requests of the young people. If any dissatisfactions or complaints were raised, these were also discussed and acted on by the team.

There was a complaints policy in place which outlined the procedures for both formal and informal complaints. This policy and procedure were currently under review as an action from a previous inspection in a sister house which was undertaken in April 2022. Staff were aware of the procedures for dealing with a complaint when asked during interview.

The young people were given an information booklet during their admission process which outlined details about the centre and the team. It included information about 'Knowing Your Rights and Responsibilities' and 'If you have a complaint'. There was detailed information about external agencies the young people could access such as Empowering Young People in Care (EPIC), the Ombudsman for Children (OCO) and Tusla's complaints portal 'Tell Us'.

The staff in the centre were aware of their role as advocates for the young people and gave descriptive details about the complaints process during interviews. The staff were aware of their responsibilities in receiving the complaint, reporting it to senior management and knowing who was responsible for the follow up. Complaints were discussed at team meetings and at significant event notification (SEN) review panel meetings. They were reported on in the monthly house reports that were sent to the director of services and the managing director.

Inspectors reviewed the complaints register and related complaint documentation. Both the centre manager and the managing director stated that a review was planned for June around the whole complaints process and policy. Inspectors found that the current system was lacking the ability to identify a threshold for the difference in informal and formal complaints. The complaints made since November 2021 were identified as informal but followed the procedure for formal complaints as they were sent to the social workers as an SEN. The centre's policy outlined that if a complaint was made on behalf of the young person, that it must include their consent. Inspectors saw numerous complaints made on behalf of the young people but couldn't see how/where it reflected their consent given. The complaints process required development in detailing the outcome of the complaint, including the feedback to the young people and stating whether the complaint was opened or closed. Inspectors were informed that a new system, Client Information Database (CID) was being piloted in a sister centre and that with this system in place, the

complaints process would run more efficiently and would capture the above deficits noted. Inspectors were informed there were two complaints currently opened that were being discussed at a senior manager meeting in June, as it was an organisational change that would occur as an outcome.

Learning outcomes were discussed during interview and noted through file review in changes that occurred relating to financial support for religious outings for the young people, understanding and acceptance of new cultural norms and sourcing equipment for facilitation of cultural practices. These issues were discussed at senior management meetings and the changes were implemented across the organisation.

Social workers stated in interview that they were notified of any complaint by SEN, email or by phone. The progress reports they received from the centre also outlined if there were any dissatisfactions and how the centre was dealing with it. The young people in their questionnaires stated they felt listened to by the staff when they raised their concern and that they saw the changes that occurred as a result.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager and senior management must review the complaints procedures to ensure thresholds are established, that the young person's voice is captured in the feedback and that all required details are recorded about the status of complaints.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The structure of the management team was known by the staff when asked in interview and they were able to identify all roles from the social care worker, social care leader, team leader, centre manager, director of service to the managing director. The current manager and team leader were qualified and had the relevant experience for their respective roles. Inspectors noted that leadership was evident throughout the file review with oversight from both the centre manager and the team leader where their comments and guidance were seen in the documentation. In interviews, the staff spoke of the support they received from management through their supervision, during handovers and in general on a day-to day basis. The staff stated that management were approachable if they had any questions, and their style was very much an open-door response to the team. Social workers gave feedback of a positive experience working with the management and team in the centre. It was reported to inspectors that contact was effective, and that management were visible with their leadership skills when social workers were onsite.

Governance arrangements were in place within the structures of the organisation and staff were aware of the roles and responsibilities of those from social care worker up to and including the managing director. Staff informed inspectors they were provided with a job specification as part of the hiring process. The centre manager completed monthly reports for the director of services and managing director which outlined aspects of care and operations such as staffing, maintenance, supervision. The team leader completed audits on training and health and safety. The director of service completed audits on the young people's files, however these were not very robust audits completed by the director of services and showed little evidence of their oversight and leadership. The current audits on young people's files had actions attached that were followed up by the centre manager and the team leader. Inspectors noted that while audits occurred, and actions were followed up there was a lack of oversight around organisational improvements being identified by senior management to better the service. Inspectors were informed that changes will occur

organisationally which included linking audits to the national standards, capturing governance issues and identify gaps resulting in quality improvements for the centre.

The service level agreement was in place and meetings were scheduled with Tusla Child & Family agency representatives for the following years tenure. Monthly reports were sent to the funding body outlining the progress of the young people and the governance aspects of the organisation.

The centre manager was identified as the person in charge and had a clear understanding of the role and responsibilities which was evident in their work. The centre manager was currently covering a maternity post. The team leader acts up when the centre manager was absent.

Organisational policies and procedures were reviewed and updated in June 2021. Inspectors reviewed a sample of team meeting minutes. Policies were on the agenda for discussion, however the team didn't participate in any policy review in the sample minutes seen. Inspectors were informed of a management meeting taking place in June where some policies were due to be reviewed. The managing director stated that with the introductions of the new documentation system, this would create clearer structures around the documentation used and as a result may require updates to policy to reflect these and link them together. The current policies were linked to the National Standards for Children's Residential Centres 2018, (HIQA).

There was a risk management framework in place in the centre. The young people had individual absent management plans (IAMPs) in place and individual risk assessments were completed when required. Individual risk assessments were reviewed and updated regularly. There was a centre risk register in place, reviewed monthly by the centre manager. The company risk register held all risks identified across the organisation for each centre and recorded risks specific to children rather than just the company. Inspectors recommend a review of the company risk register and risk matrix to ensure risks identified were related to the company and not to the young people.

There was a delegation log in place for staff which was managed by the centre manager. Both the centre manager and the team leader met weekly and divided tasks for the week ahead. Some staff also had specific roles such as the health and safety officer, Covid 19 Officer and Risk assessment Officer.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The managing director and the director of services need to ensure that there is improvement in the auditing in place by external managers for the service.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

Workforce planning was undertaken at all levels from the centre manager, director of service and the managing director to ensure safe and effective care and support was delivered to the young people. Staffing was discussed between centre management and at senior management meetings. Recruitment drives were ongoing since January 2022. There was a centre manager, team leader and six social care workers when inspectors were onsite and there were two vacancies in the centre, however since the inspection occurred, the inspectors were provided with an up-to-date staffing list which now meets the minimum staffing requirement. There were only three relief staff identified on the original information form. Inspectors had noted 10 other staff who had worked in the centre that had been identified through reviewing daily logs and rosters. This form was updated and sent to inspectors again which identified the relief staff that had been missing from the original form.

The centre was utilising an emergency roster since January 2022 which will remain in place until August, with the expectation that all vacant posts were filled by this time. The rosters reviewed by inspectors identified two staff members per day, and there was no day shift in place for the majority of the rosters reviewed. Staff outlined in interview that the impact of staff shortages was affecting the key workers completing the activities and sessions with the young people. This was only for a short period of time and inspectors found that the young people were not impacted negatively. As a result of this, weekend rosters were reviewed by centre management for this purpose and extra staffing was put in place on some weekend days to help accommodate the key working sessions taking place. The staff team stated they were managing to keep up to date with most of the paperwork but sometimes reports were late only by a few days. Staff also reported that both the centre manager and the team leader had stepped in to assist with the day-to-day tasks in the centre, supporting appointments and completing overnights when needed. The managing director and director of services must ensure sufficient numbers of staff remain on each shift to undertake key working tasks with the young people.

A sample of staff files were reviewed, and updates were required around completing induction forms, having signed contracts on file and the relevant interview notes.

Despite the staff shortages that had been identified while on site, the centre had a low turnover of only two staff leaving: one for college and the other for a senior position. The majority of the full-time staff had been working in the centre for over five years. There was a staff retention and well-being policy in place. An Employee Assistance Programme (EAP) was also in place. Inspectors asked staff about what supports they received and named regular supervision, training, the HR support, facilitation to complete external training and that they enjoyed the work with the young people.

There was an on call policy in place. Inspectors reviewed the on call roster which was overseen by centre managers, team leaders and the director of service who all rotated in being on call. The staff members were aware of where to find the roster and when to notify on call.

Compliance with regulations	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The managing director and director of services must ensure that there are sufficient numbers of staff on each shift to ensure key working tasks are completed with the young people.
- The managing director and director of service must ensure that human resource files have all the relevant documentation completed for the staff employed.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager and senior management must review the complaints procedures to ensure thresholds are established, that the young person's voice is captured in the feedback and that all required details are recorded about the status of complaints.	Complaint Procedure was reviewed by Management on 07.06.2022. New database system has been implemented in this centre and across the company which has an updated complaints procedure.	As a company we have introduced a new computerised logging system. This system is designed to have a clear concise workflow pattern. When an event is logged the system follows a clear path and notifies relevant parties automatically. Complaints now logged on the system which: Identifies type of complaint (formal, informal) What action has been already been taken and by whom What action needs to be taken and by whom When logged it is automatically sent to management for their review and electronic signature in a workflow manner. Relevant parties will be automatically notified of a complaint, and it will remain

			in their inbox until actioned, i.e., elevated or signed as closed. Complaints will be specifically discussed by managers and senior management at SEN review meetings. A new key working template has been drawn up to ensure YP are clear on the procedure. Complaints policy was reviewed. New Complaint Log compiled.
5	The managing director and the director of services need to ensure that there is improvement in the auditing in place by external managers for the service.	A new auditing template has been drawn up and is currently being trialled in one of the other services within Misty Croft with the aim for it to be implemented across the company by 2023. A schedule is in place for 2023 for audits to be implemented and carried out by the Director of Services and Managing Director of Services.	As mentioned, Director of Services and Managing Director have worked on a new auditing template its currently being trialled in one of the other units, it is based on National Standard's for Children in Residential Care themes and the aim is for it to be implemented across the company by 2023. Based on the trial the template may require amendments/ updates.

6	The managing director and director of services must ensure that there are sufficient numbers of staff on each shift to ensure key working tasks are completed with the young people.	As a result of the recruitment drive two new SCW's were hired which alleviated the staff deficit.	Management will continue to ensure adequate staffing levels are maintained and have even engaged a fourth agency service should any deficits in staffing levels occur or if our relief panel is unable to fulfil the vacancies until such time as a social care worker can be recruited.
	The managing director and director of service must ensure that human resource files have all the relevant documentation completed for the staff employed.	Copy of signed contract now on SCMs file.	Management will continue to carry out staff audit files to ensure all relevant documentation is present.