An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care Inspection and Monitoring Service

Children's Residential Centre

Centre ID number:	**062**
Year:	**2018**

Alternative Care Inspection and Monitoring Service
Tusla - Child and Family Agency
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Registration and Inspection Report

Inspection Year:	**2018**
Name of Organisation:	**Salvation Army**
Registered Capacity:	**Seven young people**
Dates of Inspection:	**23rd and 24th October and 6th November 2018**
Registration Status:	**30th of November 2016 to 30th November 2019 with attached conditions**
Inspection Team:	**Eileen Woods Catherine Hanly**
Date Report Issued:	**8th of May 2019**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration on the 30th of November 2004. At the time of this inspection the centre were in their fifth registration and were in year two of the cycle. The centre was registered without conditions from the 30th of November 2016 to the 30th of November 2019.

The centre's purpose and function was to accommodate seven young people on an emergency only basis for a maximum of seven to fourteen days. The age range was twelve to eighteen years. Their model of care was described as to provide a place of safety, support and advocacy for young people in crisis.

The inspectors examined standards 1 'purpose and function', 2 'management and staffing' and selected criteria of 5 'planning for children and young people', 6 'care of young people' and standard 10 'premises and safety' of the National Standards For Children's Residential Centres (2001). This inspection was announced and took place on the 23rd, 24th October and the 6th November 2018. A further meeting with centre management took place on the 8th of February 2019 with regard to the findings of this inspection. The Registrar and Chief Inspector issued a letter to the centre on the 1st of March 2019 following a Registration Panel meeting proposing that within 21 days the inspectorate may attach specific conditions to the registration status of the centre. A meeting was held with the manager and the regional manager of the centre on the 20th of March 2019 whereby there was discussion of the actions taken to date on the implementation of the CAPA. A Registration Panel meeting on the 29th of March was

appraised as to the outcome of this meeting and the decision was taken to continue to register this centre and to attach a condition that there must be full implementation of the CAPA. This will be reviewed within a focused timeframe by the inspectorate.

1.2 Methodology

This report is based on a range of inspection techniques including:

- An examination of pre-inspection questionnaire and related documentation completed by the A/ Manager.

- An examination of the questionnaires completed by:
    a) Four of the social care staff
    b) The Deputy manager

- An inspection of the premises and grounds using an audit checklist devised by the Health and Safety and Fire and Safety officers of HSE on our behalf.

- An examination of the centre's files and recording process.
    - Internal management meetings
    - Team meetings
    - care files
    - supervision records
    - handover book , registers, daily logs
    - maintenance log, fire safety folder
    - observation of a team meeting
    - observation of a handover
    - observation of a morning routine

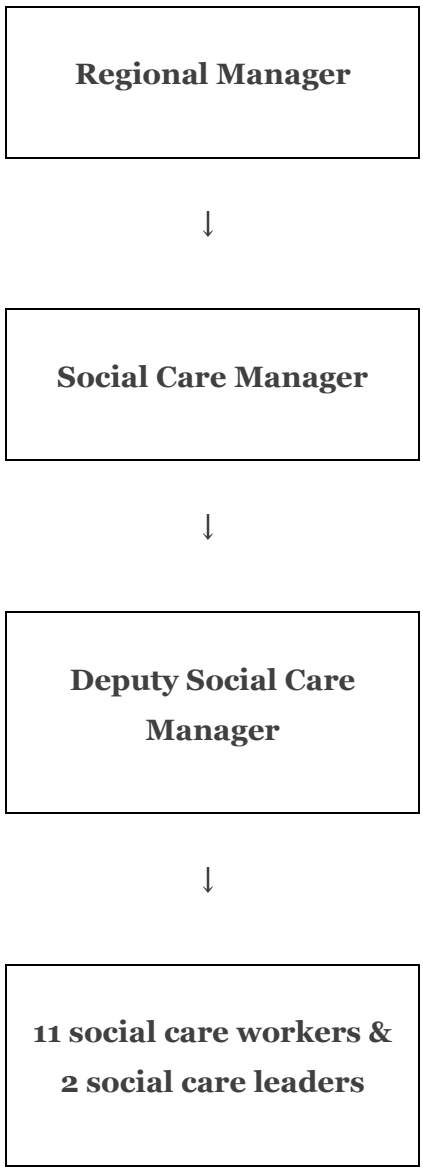
- Interviews with relevant persons that were deemed by the inspection team as to having a bona fide interest in the operation of the centre including but not exclusively
    a) The acting social care manager
    b) The deputy social care manager
    c) The deputy regional manager salvation army
    d) A social care worker
    e) The lead inspector
    f) The Tusla Out of Hours/Crisis Intervention Service Alternative Care Manager

- Observations of care practice routines in the evening and the morning.

Statements contained under each heading in this report are derived from collated evidence.

The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the staff and management for their assistance throughout the inspection process.

1.3 Organisational Structure



2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, assistant regional manager and the principal social worker and alternative care manager of the Crisis Intervention Service Tusla on the 9th of January 2019. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a completed action plan (CAPA) on the 7th of February 2019 following the granting of an extension to the response timeframe. A meeting was held with the centre manager, the deputy manager and assistant regional manager on the 8th of February 2019. The Tusla Principal Social Worker for the Crisis Intervention Service also responded to this report. The Registrar and Chief Inspector issued a letter to the centre on the 1st of March 2019 following a Registration Panel meeting proposing that within 21 days the inspectorate may attach specific conditions to the registration status of the centre. A meeting was held with the manager and the regional manager of the centre on the 20th of March 2019 whereby evidence was discussed of the actions taken to date on the implementation of the CAPA. A Registration Panel meeting on the 29th of March was appraised as to the outcome of this meeting and the decision was taken to continue to register this centre and to attach a condition to its registration that there must be full implementation of the CAPA.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be not continuing to operate in adherence to the regulatory frameworks and Standards in line with its registration. As such it is the decision of the Child and Family Agency to propose to register this centre, ID Number: 062 with an attached condition from the 30th of November 2016 to the 30th of November 2019 pursuant to Part VIII, 1991 Child Care Act.

The following condition was proposed to be attached to the centre's registration under Part VIII, Article 61, (5) (b) (I) (II) of the Child Care Act 1991, at that time. The condition being that:

1. That there is full and effective implementation of the action plan/CAPA in order to bring the centre into compliance with relevant standards and regulations.

The period of registration being from the 30th of November 2016 to the 30th of November 2019.

3. Analysis of Findings

3.1 Purpose and Function

Standard

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

3.1.1 Practices that met the required standard in full

None identified

3.1.2 Practices that met the required standard in some respect only

This centre provides short term emergency accommodation for young people in crisis up to a registered capacity of seven young people in the age range of twelve to seventeen. The centre opens at 5 pm until 9.30 am Monday to Friday (Mondays 6.30 pm) and 5 pm to 1.30 pm Saturday and Sunday. Referrals are routed through the dedicated Tusla out of hours social work team and crisis intervention day team (OOHs/CIS) who manage the beds and deal directly, particularly initially, with the relevant social work department. On occasion direct referrals are made from social work departments to the centre. The centre is run by a voluntary body.

There was a written statement of purpose and function that had been dated as reviewed in May 2018. The acting manager stated that the content had not required revision since the 2016 review. Inspectors found that the statement of purpose and function does require review as it was not entirely accurate and up to date regarding the service being provided. The acting manager described fourteen nights as the maximum length of stay and this is not outlined in the purpose and function document inspectors reviewed. The statement of purpose and function does not fully outline the service it aims to provide and the policies referenced in one instance referred to a HSE policy rather than a current Tusla policy.

Inspectors established that the staff knew the core purpose of the centre. The staff and the centre management stated that the purpose was not in fact reflected in practice with regard to the seven to fourteen day timeframes for the use of the emergency accommodation and this applied to a recurring cohort of the young people accessing the service. This they said was due to a lack of suitable move on placements for young people presenting with significant needs. The number or

percentage of young people this applied to had not been formally analysed by the organisation but from inspectors initial review this appeared to be just under a third of placements in 2018, accurate figures later confirmed this to be just under a quarter of young people in 2018, 28.7% or 33 young people. Therefore over 70% or 82 young people left in accordance with the recommended minimum stay. The staff team stated that due to the delays in moves and its impact on the young people that the place of safety, advocacy, support, advice and guidance goals of the model of care could not be consistently met.

Inspectors found that the feedback of the staff was upheld by the evidence viewed on the registers and records at the centre. The day to day operation of the centre was therefore not fully reflecting the statement of purpose and function in the length of stay and in the application of the programme of emergency/crisis care. Staff cited issues in the number of beds available being too high given the complex presentations, staffing being too low for key parts of the evening, lack of suitable risk assessment tools and lack of a guaranteed full day service from Tusla for young people as being inhibitors to the full implementation of a well functioning service. The mix of age ranges at key times was also named as a difficulty. Following the inspection an agreement was reached between Tusla and the centre to implement interim increases in staffing levels at key times and longer opening hours. This was stated as due for formal review in April 2019. The PSW for the CIS also highlighted following the inspection that records were kept of the CISP/day project workers and that these evidenced a high level of regular contact between the centre and the project workers. They also clarified that it is not the role of the CISP to provide a day service to the young people, this rests with the relevant social work areas.

A sample of six files for current and recent young people contained multiple areas of reference and recordings by staff that stated their evidence of a sharp decline in some young people's emotional presentation and noted the exposure of different age groups to each other as a negative or causative factor in this. Inspectors established that there had not been and nor was it planned by the voluntary body or by the Tusla crisis intervention service to assess this evidence or to implement an operational review at this time. Inspectors found that such a process is urgently required.

Inspectors reviewed the register of young people for 2018 and found that of 59 admissions there had been 19 of these readmitted and/or not discharged in accordance with the timeframes:
10 young people – 2 admissions
11 young people – 3 admissions

2 young people – 4 admissions
1 young person – 6 admissions

The returning manager later clarified that statistics are maintained and that these can be accessed at all times for interim updates. They clarified that in 2018 that 28.7%, which represented 33 young people, had stayed beyond the 14 days. These figures were as follows:
15-20 days - 9 young people
20 plus - 10 young people
30 plus - 8 young people
50 plus - 2 young people
60 plus – 1 young person
80 plus – 1 young person
90 plus - 1 young person

Thirty one young people with care status of voluntary and full care orders re-accessed the service for time periods varying from one to 80 days. The overall total of young people who accessed the centre with a care status was seventy two. These are 2018 figures.

The centre staff outlined that upon readmission they found a decline in some young people displayed through for example, increased substance misuse, coming to the attention of Gardaí, less inclined to positively engage with the team. In 2018 property damage resulted in a number of the beds being closed, one of those occasions resulted in significant repairs to walls and ceilings across three affected bedrooms.

The statement of purpose and function must be reviewed and this process must be informed by a full review of the internal governance and the interagency working arrangements between Tusla and the organisation in support of improvements in the safety for young people.

Inspectors also noted that the immediate physical environment around the centre had visible social problems related to drug activity. The young people were encountering an actively unsafe social environment as soon as they leave the front door. The organisation have made proposals over recent years to provide a day service to young people but stated that they have received no definitive answer on this matter from Tusla. Discussions on this matter have now been renewed since this inspection.

3.1.3 Practices that did not meet the required standard

None identified.

Required Action

- The statement of purpose and function must be reviewed and brought up to date.
- The policy document must also be reviewed and reference policies and up to date legislative changes in relevant areas.
- The capacity and age range must be reviewed based on the centres, inspections and out of hours service findings with regard to service provision.
- The Tusla Crisis Intervention Service must review its day time service for vulnerable young people accessing accommodation at this centre.

3.2 Management and Staffing

Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

3.2.1 Practices that met the required standard in full

Notification of Significant Events

The centre maintains a defined system of notification of significant events. The incident reports were sent to the lead inspector, the Tusla ACM (alternative care manager) and the social work departments for the young people. The lead inspector found that the volume of incidents presented a risk profile at the centre of individual risk to young people and group impact risks also. The lead inspector also noted and this inspection confirmed that there was an absence of dynamic review of trends and outcomes from significant events at the centre.

There was a register of significant events and there was evidence of communication with social workers for the young people in response to the significant events that took place. There were also responses from the CIS ACM and actions, where available, put in place to support the centre and young person.

Training and development

There was evidence that a lack of access dates to the Tusla run therapeutic crisis intervention/TCI programme was having an impact on the training timeframes for relief staff. In one confirmed situation that deficit was ongoing since late 2017.
There was evidence that other core training was organised for the full time staff. The manager reported that training was up to date for first aid, Children First and fire safety.
There was evidence of additional complimentary training and briefings, for the team, for example the therapeutic use of daily life events. There were good interagency links suitable to the needs of the young people with a local drug treatment centre and with the community and child protection Gardaí for that area.

3.2.2 Practices that met the required standard in some respect only

Management

This service had a management structure that comprised of a manager and a deputy manager (a job share post) covering two projects under the one roof. The service being inspected in this instance was the night time emergency centre located in the basement and first floor of this property. There were two dedicated social care leaders who operationally ran this project; their work was overseen by the manager and deputy.

At the time of this inspection the manager was on leave and one of the deputy managers, who normally job shares the deputy post, was acting up into the manager post four days per week and the other deputy was also working four days per week to cover the deputy post. The full time manager was due back to their post in November 2018 following which the deputy managers would revert to their previous job sharing arrangement. As part of a predominantly UK and Northern Ireland based voluntary body the line managers for this service were based in Belfast and the service was operated in accordance with the wider operational procedures and mission statement of this voluntary body.

The managers of the centre were experienced and qualified having run this project for many years. They had systems in place that structured how they provided internal governance and oversight these included weekly team meetings, daily contact with social care staff at handover, observations of morning routines and review of significant event reports. The acting manager stated that the goal was to also formally meet the social care leaders bi monthly at the centre. They completed a satisfaction survey with young people from time to time to seek feedback and have a weekly take away to promote engagement and feedback from young people to the social care staff.

The external oversight was stated to be through the Belfast based regional manager; at the time of the inspection the deputy regional manager was completing this role. The acting centre manager stated that three monthly service reviews were completed for which they complete a service review form. The acting manager also stated that phone and email contact is continuous with the management in Belfast. Inspectors requested evidence of this external management system. No further written evidence was provided but discussion did take place regarding same at a meeting on the 8th of February 2019 between the service management and the registration and inspection team management.

Internal governance meetings took the form of quarterly senior team meetings and regular programme review meetings; the latter involved solely the managers and social care leaders also. These evidenced ongoing oversight of existing systems such as training and staff support for example. The records of the programme reviews showed that these were a mix of monthly and at times two monthly intervals in 2018. These records highlighted ongoing management of health and safety, the programme delivery for individual young people, the property and training. There was no record of the external line management attending these meetings nor of them providing feedback or input into them.

Interagency meetings in place were said to be social care leaders meeting the team leaders from the out of hours team three monthly, a shared significant event review group with other services in the crisis intervention service and a three weekly emergency managers forum again for the crisis intervention service managers from a range of centres. No records were available to inspectors from these meetings but the managers relayed that these were largely support and discussion meetings and not specific to operational practices and risks at this centre.

Inspectors found that existing governance systems were not reflective of the stated urgent issues named by staff and management about the service. Inspectors also found that there was no dedicated audit or quality assurance process in place specific to this service. There was no evidence of a mechanism through which the voluntary body was tracking the centres compliance with their purpose and function and the national standards. The centre does not operate a risk register and there was no existing system for same internally or externally in co-operation with Tusla.

The internal governance displayed ongoing areas of strength in the provision of health and safety, support, training and advice. There was no evidence of an internal escalation and response system to the repeatedly recorded "chaotic" nature of the service experience at the centre. The returning manager stated that the language used in their external communications, seen by inspectors, misrepresented the true issues and that instead of 'chaotic' that in fact the matters to be addressed related to 'complex needs'. The regional management also named that budget deficits had impacted the service with the voluntary body supplementing the service.

Inspectors found that there must be regular internal meetings dedicated to this service and involving regional management. The role of the social care leaders with regard to the extent of their responsibilities must also be reviewed as they were duty managers of the service and were noting work load issues around this in the

supervision they did receive. The introduction of an escalation system to respond to changing risk profiles for the overall service provision at the centre should be put in place and for the ongoing future of the service the external managers must evidence their oversight, audit and involvement with the service to a higher standard. The internal management should evidence their review of their existing oversight systems and how effective these systems are in responding to the demands of the service.

At the time of the inspection visit the external management stated to inspectors that consistent deficits would lead to a service review but that this was not triggered for this service as the option to have a meeting, due to the level of experienced managers in post, was to be considered first.

Register

The centres register was found to be in an A4 soft copy and contained no date of opening, no reference to indicate which number of register this was. Inspectors found that the details entered onto the register were not always completed to a good standard despite evidence of sign off by management.

There was a system in place where duplicated records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

Staffing

The staffing allocation for this centre was two social care leaders and eleven social care workers. This was in addition to the manager and deputy manager who oversaw both projects. There were thirteen relief staff available also and it was reported that the relief staff were utilised regularly. Of the eleven social care workers seven had three years experience and all the full time staff were qualified in social care. The social care leaders had the requisite post qualifying experience for their role. The managers stated that they oversaw the rota to ensure that there was someone qualified and experienced to social care leader level on the overnight shifts. This, inspectors found, was something that the service must track as inspectors established evidence of social care staff noting issues during night shifts with the balance of inexperienced to experienced staff. Post inspection the management clarified that they oversaw the rosters with the aim to have fifty percent of the staff on duty overnight as full time staff, that they review incidents and have a robust absence policy. They added that there is frequently a duty manager available on the property.

At the time of the inspection visit staff members requested that the staffing levels be increased from two staff between 5 pm and 7 pm and that staffing levels overall be

reviewed. Inspectors noted that management responded to this request and increased the available staff between these hours. Inspectors also found that staffing risks could occur in the overnights when two staff were present and one may be required to leave to assist a young person at hospital for example. In this instance inspectors were told that this would be risk managed by the on-call management system and in conjunction with the out of hours social workers and family members.

The social care leader role was prominent at the centre and was divided between responsibilities for different staff groupings on the roster. The management referred to them as duty managers. Some staff work nights only and others complete day shifts to support pursuit of move on placements for young people. The social care leaders oversaw admissions along with all staff, meetings, escalation processes in conjunction with management; they also provide supervision and were not completing all of these tasks in accordance with the existing expectations and policies at the time of the inspection. This they were evidenced as naming as being due to a busy workload.

Inspectors found that despite the challenges that the full time team were an experienced, well informed and trained group who were focused on the delivery of good and safe care to young people in crisis. Inspectors observed good skills in evidence by staff in interagency and multidisciplinary daily contact, and an awareness of the impact on young people of this period of crisis in their lives. The team were described by the management as strong advocates for young people but recent years had been challenging at times and that they had responded to this to support the team. These supports included improvements in inductions, additional training, promotion of the availability of counselling sessions, provision of team days and reflective practice sessions at team meetings. The staff and the management spoke positively about one another.

Inspectors reviewed a sample of three personnel files and found that not all the qualifications of the staff were verified. Inspectors also advised that the service ensure that they seek to minimise the use of generic references and that they standardise the quality of the verbal verifications recorded. There was evidence of formal recorded inductions provided to new staff.

Supervision and support

The policy guidelines for the provision of supervision to staff and managers were four to six weekly intervals. The structures at the time of the inspection were the social care leaders supervised the social care workers, the social care leaders were

supervised by the manager and the managers are supervised by the regional manager. The supervision records were sampled by inspectors and it was found that the four to six weekly policy guidelines for the provision of supervision had not been maintained for all levels of staff, with longer gaps over the summer time in particular. In several instances the gaps continued despite specific difficulties in project management being noted during sessions. The acting manager and the deputy had two and one sessions respectively on file with a supervisor in 2018.

The supervision provision found by inspectors did not match the profile of the service needs. The managers and the regional manager noted that ongoing informal supervision took place and that group supervisions and supports were provided and promoted on an ongoing basis and inspectors found that these did take place. The management did not name supervision as a concern with regard to governance and did not have an independent system for the review and auditing of supervision and matters arising within it.

Inspectors found that the weekly team meetings were conducted and recorded to a good standard, there were clear tasks and actions identified for immediate implementation within the nightly programme. The social care team were vocal and contributed to the discussions and decision making. There was evidence of good team discussions and an ability to work with complimentary services in support of young people, for example a drugs service coming to the centre to meet the young people.

Administrative files

Inspectors found that a file was maintained on each young person who was placed at the centre, this file was stored in the main staff office in a locked cabinet. In the event that a young person was referred back to the centre this file was accessible to staff and added to for the new admission. This resulted in a high number of confidential files for ex young people being available, albeit in a locked cabinet, in a shared office space. Inspectors recommend that this be reviewed for security arrangements so that the managers can satisfy themselves as to its ongoing safety.

Inspectors found that the files needed to be overseen for dating, signing, bringing forward accurate information when files were used for a readmission and for date stamping when an external report is received. Names and titles of persons recording and signing should also be printed if signatures illegible and previous known risks and recently used planning documents should be cross referenced in a more reliable and even manner.

There was some evidence of the internal management monitoring the quality of all centre records and there was evidence of follow up at programme meetings and team meetings on some aspects of this. Training in report writing has also been provided for staff. There was no clear evidence of how external management satisfied themselves as to the quality of the oversight work completed at the centre.

3.2.3 Practices that did not meet the required standard

None identified.

3.2.4 Regulation Based Requirements

The Child and Family Agency has met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV, Article 21, Register.***

The centre has not met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996 Part III, Article 5, Care Practices and Operational Policies.***

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 6, Paragraph 2, Change of Person in Charge
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)
-Part III, Article 16, Notification of Significant Events.

Required Action

- The organisation must implement external governance and quality assurance structures suitable to the specialised nature of this centre.
- The centre management must ensure that internal governance oversight and review is specific to and responsive to the needs of the centre.
- The management internal and external must ensure that supervision is provided in accordance with suitable policy and practice needs at the centre.
- An interagency operational meeting protocol must be agreed and implemented between Tusla Crisis Intervention Service and this centre.
- The register of young people must be improved with regard to its quality and audited regularly for content.
- Staff qualifications must be verified for the personnel files.
- The files and daily records must be maintained in a manner to best support evidencing of the care provided to the young people whilst at the centre.

- The present storage arrangement of the files for current and previous young people must be reviewed.

3.5 Planning for Children and Young People

Standard

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

3.5.1 Practices that met the required standard in full

None identified.

3.5.2 Practices that met the required standard in some respect only

Suitable placements and admissions

The matter of the need for an emergency service for children in crisis is committed to by the Child and Family Agency, Tusla. One of the ways in which they do so is in partnership with this voluntary body and its centre. The other resources are emergency foster care and the provision of privately operated emergency placements in dedicated residential centres outside the Dublin region. There were no links between these emergency service providers at the time of the inspection. The location, number of beds and lack of a centre based day service was unique to this centre. This has relevance for the acknowledgment of the impact on whether this can be assessed as being a suitable emergency placement or not. It has been stated repeatedly by the centre and other professionals that they consider the provision of a fully staffed day service at this location and rapid move on as critical to managing the risks for young people.

The Tusla CIS management do not support that a collective pre admission risk assessment tool would be suitable for this service given its purpose and function. The staff at the centre proposed that it would be an important risk planning and risk management tool. A specific tailored tool for this had not been explored as yet to inspectors' knowledge. As there were no regular operational meeting in place between this centre and their Tusla partners, strategies, service development, shared

policies and procedures and risk escalation and responses were either not discussed or were discussed on a case by case basis. Therefore whilst the parties were mutually supportive and had good working relationships they had no formal recorded mechanism for addressing issues and responding to them.

The admissions' procedure for the centre involved a referral from the day or the night social work team. Occasionally an allocated social worker will contact the centre directly and liaise with the OOH/CIS team. Young people were then admitted to the centre and an admission form completed. The young person would be accompanied by an out of hours team social worker to the centre and a handbook and explanation of the service given by staff if the young person was unfamiliar with same. This was the start of the planned seven to fourteen days' maximum stay. A planning meeting was organised within three days with the statutory case manager for the young person and the expectation was that the young person be moved to a stable placement or to family as soon as possible. This as stated had been difficult for a cohort of young people the last few years. Over three quarters of young people leave quickly to return to family, foster care or other suitable arrangements with supports.

The management and staff stated that they believed the non adherence to the fourteen day stay was due to a lack of suitable move on options for young people. The system presently is that the social work departments can refer young people to the local resource panel for a range of placements in other dedicated centres some of whom are part of the wider crisis intervention service provision. It was stated that due to the complex needs of a cohort of the young people they were at risk of not meeting the collective pre admission risk assessment criteria for those placements. There was no mechanism known to inspectors for parallel referral to the private placement team for specialised placements concurrent with this process to shorten timeframes. Thereafter a cycle of delay and decline increased the risk profile for referral onward which compounded delays for some of this smaller group of young people.

Information was gathered by the staff after admission and the centre, if they had a pre-existing file, used this and the contacts they had established prior to add to the information on the young person. Staff also spoke to the young people about what had happened for them since they last had contact with them but this inspectors found was not well captured on the records maintained. The staff engaged in practices and strategies to protect the young people from any potential negative impact from the peer group. The staff team and the records stated clearly that this

was not always fully effective when the group age range and risk profile was too diverse but was always addressed through daily/nightly planning by the team.

Inspectors found that the admissions' files could be improved through increased audit to ensure that details and dates are brought forward and also recommend that the number of re-admissions and length of previous placements be tracked on the files. The process post admission should be reviewed as it did not differentiate in its structures, including attendees at meetings from the centres side, once the placement goes beyond the initial allowed period of time or where a re-admission occurred.

Placement reports and letters from the centre for all young people consistently stated as standard that the "service is very chaotic by nature", "not appropriate" and "leads to further escalation". The management stated post inspection, as noted earlier, that this was not the accurate representation for all young people and is something they plan to address in their communications from here on.

Social Work Role and Supervision and visiting of young people

Standard

Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to their care.

There was evidence of a long term established working relationship and co-operation between the Tusla crisis intervention service and out of hours social work alternative care manager and principal social worker and the centre. There were day project workers from another organisation in post, at another location, contracted to provide supports across all aspects of the CIS service and it was not their role to provide a day service for the young people in this centre. The allocated social workers for some of the young people provided/funded day supports in the form of other organisations or companies available to them.

The centre team contacted allocated social workers after the admission of the young people and requested copies of any care plans and social histories and to verify important health and other information. The team contact families also in accordance with existing arrangements and records showed a regular level of contact

with those families and allocated social workers actively involved with the different young people.

There was evidence of social workers attending the admissions meetings and meetings called thereafter, the options of the use of professionals meetings and strategy meetings were utilised from time to time. On occasion it was evident that there were available alternate placement options prior to coming to this centre but had been refused by the young people, it is essential that the allocated social workers ensure that all avenues to avoid admission to the centre are fully exhausted and all efforts are made to divert young people from the centre, for example for a young person who has not previously been exposed to the city.

Discharges

The centre had a discharge policy in place that addressed different categories of discharge – planned, unplanned, self or emergency discharges. Each had a dedicated procedure attached and some of these procedures were evidenced on the records at the centre. There was significant communication between the CIS management and staff and the centre management and staff but the majority of this was not recorded, as by its nature was often urgent and required quick decision making. The inspectors established that where a placement was in crisis all parties sought to co-operate and communicate to address the issues arising but that options for action were limited at times.

Inspectors found that not all aspects of the procedures were firmly evidenced in the six files reviewed by inspectors in that managers were not routinely attending crisis meetings in response to placements in difficulty, nor was there evidence of a system of increasing seniority in presence at meetings once a placement went beyond fourteen days. Inspectors found that frequently, according to records seen, that it was a social care worker managing such meetings. It presented as advisable to inspectors that how discharges were managed and the pathways to all types of discharge were managed be reviewed. The procedures contained within the policy must be reviewed as part of this to ensure that they are accurate.

3.5.3 Practices that did not meet the required standard

None identified.

Required Action

- The centre management must review the structures and policies surrounding admissions, re-admissions and discharges.

3.6 Care of Young People

Standard

Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

3.6.1 Practices that met the required standard in full

None identified.

3.6.2 Practices that met the required standard in some respect only

Managing behaviour

The centre had policies and practices in place to support young people in managing their behaviour. There were rules and structures at the centre and these were described to the young people in a handbook and at their admissions meetings. There was evidence that the team had a strong awareness and took action to support young people with the level of uncertainty they faced daily.

There were team skills evident in the management of rapid admissions and flexible response to young people. There was good evidence in interdisciplinary communication. There were programmes displayed and actions in place to act as positive diversionary strategies to engage the young people with the safe adults available to them. The team created short term needs plans, individual crisis management plans, assigned link/key workers and created in placement risk assessment forms. Sometimes bespoke safety plans were implemented too. All of the files reviewed by inspectors had these documents in place and all evidenced review and updating following incidents, team meetings and handovers where necessary.

The risk assessment documents were, as stated, on each file and in most instances there were several on a file and they did serve to track the changing risks for some young people caused by the impact of exposure to instability, for example no onward placement. In particular staff tracked increases in concerns around substance misuse and emotional state. The staff did not use the matrix available on this document and the document did not function as a group impact management tool either. There was no specific feedback to inspectors as to the usefulness of this tool in practice. But

inspectors did note that there was no escalation process built into it and it did not feed into a governance system or risk register that tracked/audited or responded to them. A risk register would be a useful governance tool for tracking and acting in response to risk with the goal of reducing it. The data could be used in enhanced operational meetings with the Tusla partners and actions generated or risks held mutually.

There were sanctions in place and these were limited in range due to the specialised nature of the centre. There was management sign off on sanctions but inspectors did not observe review of the effectiveness or not of sanctions during this visit. Attempts had been made to talk to young people about any sanctions imposed and in general the full time team were well trained in de-escalation and post incident recovery with young people. Some of the sanctions available to the centre carried an additional risk factor when the option of a late referral or referral through a Garda station was utilised. Due to this the latter was only used in consultation with the allocated social worker and the CIS team would be informed and they in turn updated the out of hours social work team. Sanctions were discussed and reviewed at team meetings and with the young people through key workers.

Inspectors found that where the opportunities arose the team acted quickly and engaged well with the young people, were available to them, were knowledgeable and supportive. Many young people leave in accordance with the goal of minimising exposure to emergency accommodation. The inspectors found that the positives, strengths and successes in behaviour management were obscured somewhat at the time of the inspection due to a prolonged period of change in admissions and discharges at the centre that required a more tailored response. Some of the behaviour management planning documents should be reviewed for effectiveness and to ensure that in the individual crisis management plans that the contra-indicators to restraint where they existed were recorded clearly. It is also essential to the behaviour management implementation strategy that all relief staff are trained in TCI without undue delay.

3.6.3 Practices that did not meet the required standard

None identified

Required Action

- The management must review and implement effective risk assessment and management systems suitable to the purpose and function of the centre.

3.10 Premises and Safety

Standard

The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

3.10.1 Practices that met the required standard in full

Accommodation

The centre had been damaged a number of times in the preceding twelve months. Some due to damage caused during violent incidents and some accidental damage, inspectors reviewed the property with this in mind as well as its general presentation. A number of beds had been rendered closed for periods of time due to same. Inspectors conducted a walk through of the premises with the acting manager and found that all areas of the bedrooms and the ceiling had been repaired and walls reinforced following the most recent damage. All emergency light and sensors were reinstated and checked. All electrical work was certified by a qualified electrician. The centre had been repainted also and new furniture provided in the bedrooms. Overall the property is structurally unchanged internally since the last inspection but larger works on replacement of windows and the roof have been completed.

The centre is designed in a hostel like setting and has an industrial style kitchen to meet its needs. There was a pool table and some recreational resources evident and more were being bought or replaced. The computer room was out of use due to the knock on effects of the repairs to the other rooms and there appeared to be only one computer visible for use. Bathrooms were shared and involve some young people having to go through a corridor area with a camera present and it had not been reviewed over the years whether this meets the young people's primary care and dignity needs. Management stated that they have aimed to make the centre more homely and that although there are CCTV cameras in the hallways that young people are offered pyjamas to ensure all have dignity and respect.

Staff had a creative schedule of activities and options displayed for the coming week and weekend and there were funds available for diversion activities like cinema trips.

Maintenance and repairs

There was a part time maintenance person employed at the property and an individual maintenance request form is completed for each item requiring attention, date of notification and completion were allowed for on the form but were often not completed so it was difficult to track timeframes for completion. It was clear from other records that the maintenance person took care of items daily and organised with the manager for other appropriate professionals to complete specific repairs where needed.

Fire Safety

Inspector found that all fire safety and fire fighting equipment was operational and in their assigned location. All exits were accessible and unencumbered with a lit box running man sign in place. The fire emergency escape plan was on file and this named the six possible escape routes. A fire folder was reviewed by inspectors, this contained a record of monthly managerial checks. Fire safety procedure documents were available to staff and 'A Safe Mission' fire prevention risk assessment was completed and last reviewed in November 2017. This was a practical document which prioritised training and ongoing briefing of staff regarding fire safety. Fire drills were recorded as held intermittently throughout the year, four in 2018 at the time of the inspection. The means of escape were reviewed by the maintenance person Monday to Friday; this person also completes the weekly and monthly fire safety checklists.

There were suitable service contracts in place for the maintenance of fire detection and fighting equipment. Staff training in fire safety was recorded as completed yearly.

3.10.2 Practices that met the required standard in some respect only

Safety

The management overseen a health and safety system implemented by the organisation. Records were maintained in support of a health and safety system. The full time team were trained in first aid and had storage available for medications that young people may have prescribed to them. Inspectors found that an admissions record in the sample did not carry forward clear explanations for types of medication and the reasons for their usage from admission to re-admission, it is important that all information related to medication is clearly recorded and accounted for in the records.

Required Action

- Admission files must record what medications were prescribed and were present with a young person and the reasons why. Where a re-admission occurs the absence or presence of such medications should be accounted for the file and for information continuity.

3.10.3 Practices that did not meet the required standard

None identified.

3.10.4 Regulation Based Requirements

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996,***
-Part III, Article 8, Accommodation
-Part III, Article 9, Access Arrangements (Privacy)
-Part III, Article 15, Insurance
-Part III, Article 14, Safety Precautions (Compliance with Health and Safety)
-Part III, Article 13, Fire Precautions.

4. Action Plan

Standard	Issue Requiring Action	Response with Time Scales	Corrective and Preventive Strategies To Ensure Issues Do Not Arise Again
3.1	The statement of purpose and function must be reviewed and brought up to date.	Purpose and Function document is currently under review. The purpose and function was reviewed at a meeting on the 28th January 2019, in attendance was PSW and ACM for Crisis Intervention Service/CIS Tusla, assistant regional manager and social care manager for the centre. Part of this review was looking at timescales and how to escalate and identify risks both internally and externally particularly if the admissions are outside the length of time outlined in purpose and function. Part of the action plan from this meeting was including attendance at planning meetings by representative from CIS at managerial level if a young person was past 14 days. Updated Purpose and function to be emailed to the inspection service 14th February 2019.	Purpose and Function is reviewed annually and will be due review February 2020. The statistical information gathered at centre level will be reviewed regularly internal and externally and the impact of the purpose and function will be monitored. External meetings will include PSW and ACM of CIS Tusla. Registration and inspection will be informed of any instances of young people being placed outside of the purpose and function. Clear strategy meetings and risk escalation will highlight such cases and this would include attendance mangers at centre and CIS.

	The policy document must also be reviewed and reference policies and up to date legislative changes in relevant areas.	Full review of the policy document to be completed by March 31st 2019 and ensure that changes and correct legislation is referenced.	Policy review to be part of the service reviews which are scheduled monthly with the regional manager and any risks to be highlighted such as mis-referencing of legislative. Policy and legislative review are part of staff meetings, house meetings, programme reviews for example.
	The capacity and age range must be reviewed based on the centres, inspections and out of hours service findings with regard to service provision.	In terms of the age range this was reviewed at the meeting with CIS management on the 28th of January 2019 and whilst all present agreed that under 14 being placed in the centre is not ideal in the absence of other options this may be the only identified safe placement on the night. It was agreed that fostering would be explored as the first option. Also have discussed the use of the beds in another centre and looking at bed management in terms of the age profile of the young people. Please note there was no 12 year olds placed in 2018, three 13 year olds and nine 14 year olds.	Through ongoing regular meetings with the ACM CIS Tusla the age range will be part of the agenda. As part of daily bed management age profile is a consideration for CIS Tusla and the social care teams in the centre have the mediums through meeting, email and telephone contact to advocate for young people.

	The Tusla Crisis Intervention Service must review its day time service for vulnerable young people accessing accommodation at this centre.	The centre is currently piloting extended opening hours till 1.30pm. There continues to daily planning with CISP (the day service) in relation to the care of the young people. In terms of the planning meetings that take place with the young person's social worker a structure during the day is highlighted, discussed and advocated for.	The centre's open hours to be reviewed in February and possibly be permanent in April.
3.2	The organisation must implement external governance and quality assurance structures suitable to the specialised nature of this centre.	Service reviews take place monthly these include reviewing staff files, young people's files and ensuring the centre is compliant with the national residential standards.	Clear expectations in terms of governance both external and internally have been discussed and agreed and time frames in terms of completing and evidencing governance.
	The centre management must ensure that internal governance oversight and review is specific to and responsive to the needs of the centre.	Centre management will ensure that clear reviews of trends and statistics and that these are discussed with regional management, external stakeholders and in staff meetings, house meetings and programme reviews.	Agenda for internal and external meetings to ensure to include clear discussion in relations to issues being raised through governance and how these should be escalated or responded too.
	The management internal and external must ensure that supervision is provided in accordance with suitable	Centre and regional management to review supervision and time frames as part of service reviews.	Centre and regional management to review supervision and time frames as part of service reviews.

	policy and practice needs at the centre.		
	An interagency operational meeting protocol must be agreed and implemented between Tusla Crisis Intervention Service and this centre.	Interagency meetings are agreed and will be minuted and scheduled for every 6 weeks and there will be quarterly meetings including regional management and principal social worker level. Both of these initial meetings have taken place and agreed propose and time frames have taken place.	Improved regular meetings will ensure that issues identified in this report should be reduced.
	The register of young people must be improved with regard to its quality and audited regularly for content.	A new register will be opened on the 1st of March 2019.	The register of the young people will be part of the service reviews with the regional team and also will be part of reviews with the social care team.
	Staff qualifications must be verified for the personnel files.	All staff files have been audited by the social care management and the regional manager on 24th January 2019. The files that did not have the qualification verification were of those who have just qualified and this has been followed up at Centre level.	Checklist for personnel file in place and all verifications in place prior to the social care workers commencing work in the instances where the relief staff member is still studying social care once qualified certs and verification to be sought. Letter from college to confirm that the social care worker is studying social care.

	The files and daily records must be maintained in a manner to best support evidencing of the care provided to the young people whilst at the centre. The present storage arrangement of the files for current and previous young people must be reviewed.	Review of the files and referral form ongoing and to be completed by the February 28th 2019 to include information such as previous admissions, previous length of time young people's presenting profiles and risk assessments will inform the risk register that due to be implemented on the 1st of March 2019. This will help in advocating for the young people and will evidence young people positive improvements and declines. Currently exploring moving a filing cabinet to a locked unused room in the centre. This would be for the files for those who have accessed and are still under 18 and therefore could access in the future.	Through internal monitoring ensure that risk assessments are measured and inform advocacy letters and risk escalation.
3.5	The centre management must review the structures and policies surrounding admissions, re-admissions and discharges.	Currently reviewing the policies in light of the draft inspection report and have looked at the referral process and in conjunction with CIS can we improve the admission process. Currently examining the process with other services.	With annual policy review and ensure as part of the annual review ensure that the evidence gathered at centre level is utilised in review.

3.6	The management must review and implement effective risk assessment and management systems suitable to the purpose and function of the centre.	Risk register to be introduced and be in place by the 1st March 2019. Internal significant event reviews to continue and ensure that the results can serve as a tool in risk escalation and the same for external significant event review group meetings which happen every 6 weeks	Risk registrar will be a fluid document with risks being opened and closed. Risk registrar to be reviewed at the staff meetings weekly and in programme review monthly and in service reviews with the regional manager.
3.10	Admission files must record what medications were prescribed and were present with a young person and the reasons why where known. Where a re-admission occurs the absence or presence of such medications should be recorded for the file and for information continuity.	Amendments to our current medication record template to include named areas.	Regular file monitoring takes place and ensure information is present and updated with clear information relation to change in medication.