An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 096

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Three Steps**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of Inspection:	**12th, 13th , 19th and 25th August 2020**
Registration Status:	**Registered with attached conditions from the 20th of March 2019 to 20th March 2022**
Inspection Team:	**Linda Mc Guinness** **Orla Griffin**
Date Report Issued:	**22nd December 2020**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance 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 monitor the on-going 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 13th March 2013. At the time of this inspection the centre was in its fourth registration and in year two of the cycle. The centre was registered from the 20th of March 2019 to 20th March 2022 without attached conditions.

The centre's statement of purpose set out that it was to accommodate four young people of both genders from age thirteen to seventeen years on admission. Their model of care was described as attachment and trauma informed care delivered through the person centred approach and which strived to create a therapeutic alliance in a structured home like environment. There were three young people living in the centre at the time of this inspection.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
3:Safe Care and Support	3.1.1
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

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 and to the relevant social work departments on the on the 28th September 2020. 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 8th November 2020. The assessment of the submitted CAPA concluded that until the actions set out in the CAPA are fully realised the centre could not be deemed to be in full compliance with the regulations. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 096 with the attached condition from the 24th November 2020:

- There must be no more admissions to the centre until the submitted corrective and preventative action plan has been implemented and the centre is fully in compliance with *Child Care (Standards in Children's Residential Centres) 1996, Regulation 5 Care and Operational Practices*.

This condition will be reviewed on or before 24th of March 2021.

3. Inspection Findings

Regulation 16 Notification of Significant Events

Theme 3: Safe Care and Support

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

The organisation's child protection and safeguarding policy had been updated and signed off by the CEO on 20th June 2020. However, inspectors found that this policy was not fully in line with Children First, 2017 or relevant legislation and did not provide correct information particularly in respect of reporting. Further, the policy did not contain information relating to a number of key safeguarding practices including safe recruitment and vetting of staff, protected disclosures and bullying. Some of these policies were in existence elsewhere but had not been reviewed since 2016. In line with Children First, 2017 if young people are allowed access to the internet where they could be exposed to harm or abuse there is an obligation to ensure that procedures are in place to manage that risk. The practice in the centre was not congruent with the risks outlined in the organisation's child safeguarding statement and measures to manage these. Inspectors note that the child safeguarding statement was due for review in April 2020 and that this was identified as an outstanding action in an internal audit in June 2020 but was not yet actioned. There was not an effective system in place to identify shortfalls in policy, procedures, knowledge or practice and to take timely remedial action where necessary.

Staff members had completed the Tusla E-learning module: Introduction to Children First. The organisation had also sourced external child protection training and recently provided staff with training in the organisation's child protection policy. However, during interview and from a review of returned questionnaires, inspectors found that management and staff members were not clear in respect of the statutory mandated reporting procedures under Children First, 2017. There was a misconception that the manager could make a report on behalf of staff members. The mandated persons in the centre were not registered on the Tusla reporting portal and said they would not be confident in making a report unless it went through centre or organisational management. A review of interview and file records evidenced that management and the team did not have a clear understanding about thresholds for reporting. There was a clear impact on safeguarding practice in this respect. From the sample of information, inspectors identified three occasions that

child protection reports were not made at the first opportunity. For example a child protection report was not made to Tusla until after it was requested by a Guardian ad Litem and allocated social worker despite the fact that it met the threshold for reporting. The centre's child protection policy did not reference joint reporting procedures.

The 2019 Tusla inspection report for this centre identified non-compliance issues under this standard specific to child protection policies and reporting procedures which were to be addressed as part of the corrective and preventative action plan by 30th September 2019. Inspectors found that a number of actions had not been effectively addressed and the service continues to be in non-compliance with National Standards for Children's Residential Centres, 2018 (HIQA) and Children First: National Guidance for the Protection and Welfare of Children, 2017.

From review of the records and interviews, inspectors noted that a specific incident was not managed, recorded or reported in line with Children First: National Guidance for the Protection and Welfare of Children, 2017. There was no evidence that this event was reviewed as a serious incident in line with centre policy. Inspectors found that the actions of staff during the incident were not in keeping with best practice the young person subsequently came to significant harm. There was a lack of evidence that efforts were made to return the young person to a place of safety despite management receiving information from a number of sources to say that they were at risk.

A child protection and welfare report form was not submitted to Tusla until two days after the young person returned to the centre despite there being sufficient evidence that there were immediate reasonable grounds for concern. Inspectors found that much of the documentation relating to the incident including contacts and individual work records had not been completed six days after the incident had ended. The director of care must ensure that all reports relating to follow up after a serious incident are completed in a timely manner. A professionals meeting took place and some interim measures were agreed but inspectors did not receive evidence of a written updated safety plan following the incident.

While reviewing complaints as part of child protection and safeguarding inspectors found that aspects of the policy were not consistently adhered to including; making information available about how to make a complaint, accepting verbal complaints, recording complaints on centre registers and the tracking and monitoring of complaints. The policy stated that people who have a family member being cared for

by the organisation and people who have someone they represent or advocate for being cared for by the organisation can make a complaint. This was not evident in practice. Inspectors found that family members and a Guardian ad Litem had raised concerns and made complaints relating to the safeguarding and welfare of one young person. These related to individual areas of vulnerability and safeguards required. Inspectors found that these concerns were not sufficiently addressed by the management and staff team although the social work department indicated that these issues were discussed on an on-going basis in monthly core and strategy meetings. There was no record on the complaints log of the expressions dissatisfaction from family or professionals involved with young person in placement specific to these issues. They were not referenced in the interview with the social care manager when exploring complaints policy and current status of complaints. There was no record of any investigation, conclusion or correspondence with the complainants in centre records. It is noted that complaints were passed on to the social work department and the organisation will need to review its own policy if it is not to engaging directly or communicating with family members or professionals making complaints.

Inspectors found that appropriate action was taken when one young person in the centre was being negatively impacted by others and they informed inspectors that they then felt safe in the centre. The social worker for this young person was satisfied that appropriate phone and internet restrictions were in place.
There was evidence that individual work was taking place with young people in relation to risk, consent, sexual health and that discussions were taking place about self-care and keeping safe. There was evidence that young people spoke to staff if they felt unsafe.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**None Identified** **Not all standards were assessed during this inspection*
Practices met the required standard in some respects only	**None Identified** **Not all standards were assessed during this inspection*
Practices did not meet the required standard	**Standard 3.1**

Actions required

- The chief operations officer must review child protection and safeguarding policies in the centre and ensure that they are consistent with Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The director of care must ensure that all staff understand their obligations under Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The director of care must take actions to regularly ensure that centre practice is in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The directors of care must conduct a review of the incident for one young person in which they were exposed to significant harm.
- The services manager must review the processes for communication and cooperation for multiagency and multidisciplinary activity (to include the management of complaints) and ensure that all professionals can work together in the interests of young people.

Regulations 5 Care practices and operational policies
Regulation 6 (1 and 2) Person in charge

Theme 5: Leadership, Governance and Management

Standard 5.1 – The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

Prior to the inspection the organisation had sourced an external company and set up a working group to review and update their policies and procedures in line the National Standards for Children's Residential Centres, 2018 (HIQA). Some policies, such as child protection and complaints, had been updated and communicated to the staff team. The inspectors were informed that this policy and procedure review was expected to be completed and signed off imminently and that further training would be provided to centre staff.

Inspectors found that there was a significant delay between the introduction of the National Standards for Children's Residential Centres, 2018 (HIQA) and the pending completion of review and update of centre policies. Inspectors reviewed the proposed final suite of policies and found that a number of required policies were not in line with regulations or national standards. A significant number of operational policies in place were last reviewed in 2016 and did not refer to updated or current legislation. These included information management of information under GDPR (2018), access to information, behaviour management, health, recruitment and induction, children's rights and protected disclosures amongst others. The requirement to prioritise updates to policies and procedures was identified in the last three inspections for centres within the organisation. This must be addressed as a priority now.

Members of the staff and management that were interviewed during inspection demonstrated an understanding of the centre's policies and procedures and other relevant legislation for the care and welfare of children. However, as the policy was not fully in line with Children First: National Guidance for the Protection and Welfare of Children, 2018 (HIQA) they were not familiar with thresholds for reporting or the correct reporting procedures.

Some policies such as the risk management framework had been updated but not yet

communicated to the staff team but plans were in place to provide training. There was some evidence across records that policies and procedures were discussed at team level and with staff in supervision.

Management must ensure all staff members can demonstrate a good understanding of policies, legislation and national standards in the context of their day-to-day work.

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.

There was a governance system in place that detailed lines of authority and responsibility. Each staff member had a job description. The centre manager reported to a senior area manager who in turn reported to the director of care. A senior area manager was recently appointed in a quality assurance post and inspectors were informed that they would be conducting announced and unannounced audits of the centre.

Inspectors found that improvements were required in respect of leadership and oversight in the centre as issues arising during this inspection had not been identified or addressed adequately by internal governance mechanisms. There had been an interim manager in place until June 2020 when a qualified and experienced person took over the social care manager's post in the centre. This manager transferred from another centre within the organisation. From a review of questionnaires and interviews with staff it was evident that the centre manager demonstrated support to the staff team. Staff expressed confidence in the centre manager and confirmed that the senior area manager was accessible to them and visited the centre regularly. They also conducted contact meetings with staff and young people where their feedback was sought. Notwithstanding this, there were aspects of governance in the centre that needed to improve. These issues included management and staff team meetings and the oversight of child protection, supervision, complaints, risk management and Covid 19 protocols. These issues are detailed further throughout this report. Inspectors found that there were some recurring actions from both internal audits and external inspections that were not followed up or responded to in a timely manner.

The organisation had employed the services of a consultant for a 20 week period to assist with the amalgamation of two services, the transition of one young person and

the implementation of the programme of care. Inspectors found that while it was evident that the organisation had undergone a significant period of change improvements were still required to evidence a culture of learning, quality and safety within the centre.

Inspectors noted that internal management meetings had not occurred between January 2020 and July 2020 due to the Covid 19 pandemic. These meetings were to take place every six weeks according to organisational policy. Records for only two management meetings were provided for the 14 months prior to the inspection. While inspectors acknowledge the challenges posed by the Covid 19 pandemic to face-to-face meetings, the organisation should have used other forums to conduct management meetings. There was no timeframe for the resumption of management meetings and this issue was not included on the risk register. Records for the two management meetings reviewed contained discussions on care practice, rights of young people and operational matters. While there was an action plan, persons responsible for actions and a timeframe for completion, there was no evidence of discussions relating to complaints, child protection, centre audits, training or exit interviews. A June 2020 internal audit noted that complaints and child protection were not adequately included in these meetings.

Senior managers meetings were scheduled to take place every 5 weeks. These meetings were extensive divided into three parts the first of which addressed operations, HR, training, staffing, policies and procedures and risk. Part two addressed referrals, the model of care and therapeutic team, serious incident review, and protecting children, young people and adults from abuse. Planning for young people, review of inspections and responding to and learning from complaints were also reviewed at these meetings. Inspectors found that while this was a comprehensive forum and provided the basis for excellent overall governance and accountability and decision making there was only evidence of two such meetings taking place in the previous 12 months. Inspectors were informed that there was continued informal communication between the director of care and the CEO while face to face meetings were suspended. Evidence of this was provided in the directors A4 books where they recorded all aspects of their role however discussions, decision making, actions and follow up were not possible to track as in the meetings outlined above. A review by inspectors of some organisational audits found that there were recurring themes which were not addressed at senior management level.

A new system of recording significant events, child protection reports, complaints and restrictive practices was implemented. Inspectors found that open and on-going

child protection reports were not transferred to the new logs. This was not identified through senior management oversight of the centre. The senior area manager must ensure adequate oversight of centre records and registers and take action to address any gaps or deficits.

Despite open child protection issues being been highlighted in a number of centre audits and on management meeting records there was an absence of an effective escalation procedure as one long standing allegation from 2016 was still open .

There was no service level agreement in place with the Child and Family Agency and the organisation had not participated in a recent tendering process. There were arrangements in place to provide an annual report to the funding body.

The centre had risk management policies and procedures in place for the identification, assessment and management of risk. There was an organisational and a centre risk register which included staffing, fire, risk of harm, reputational damage, compliance with standards, business continuity and service user experience.

Inspectors found that there were deficits in respect of the Covid 19 protocols to guide staff if a young person presented with possible symptoms. On two such occasions no medical advice was sought to assess if a referral for testing was warranted. The young person was not subsequently diagnosed with Covid. While the centre had robust measures in place for visitors to the centre inspectors observed that these were not followed appropriately on day two of the inspection.

There was always a dedicated person to contact in case of emergency however there were no records of staff communication with the on call person or records of advice and direction given.

The centre had a management structure appropriate to its size and purpose and function. There were arrangements in place to provide adequate managerial cover when the manager took periods of leave. Some of the managerial responsibilities had been delegated to the deputy manager. There was no formal record of this in place but one was implemented when highlighted during inspection.

Standard 5.3 – The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

There were three young people living in the centre at the time of inspection. There was a written statement of purpose which was last updated in June 2020. The statement outlined the aims, objectives and ethos of the service. It did not specifically outline key policies in place to guide practice and ensure the satisfactory care of young people. The complaints policy referred to in the statement was not the current version that had been recently implemented and in which staff were trained.

Inspectors were informed through management and staff interviews that the model of care was based on a trauma and attachment model and was also informed by neurobiology. The inspectors found that the statement of purpose did not include sufficient information relating to the model of care. This did not meet the requirements of the National Standards for Children's Residential Centres, 2018 (HIQA). There was no written documentation relating to the model of care available at the time of inspection.

The staff team had received some training in aspects of the model of care. It was evident from staff interviews that they could describe the trauma and attachment part but were not confident in the neurobiology aspect of the model and they stated they had not received adequate training in this. This is a recurring theme across previous inspections of this centre and has been identifying action in three of four inspection processes which took place. The organisation had employed a senior clinical neuropsychologist and a consultant child and adolescent psychiatrist. The director of care indicated that the statement of purpose and model of care was to be re-written in consultation with the clinical neuropsychologist and a consultant child and adolescent psychiatrist. Full training was to be provided to the staff team with a timeframe of completion toward the end of 2020.

A detailed programme of care which included a clinical neuropsychology assessment for each young person was provided to inspectors. This had begun for some young people across the organisation's children's residential centres. All social workers interviewed felt that their young people were making progress in their placements in the centre. This was evidenced through reduced significant events, return to education and better engagement with the staff team. Senior management must ensure that when fully implemented, the implementation and effectiveness of the programme of care is subject to evidenced evaluation as part of organisational governance to ensure that care is being delivered in line with the revised statement of

purpose.

Information on the centres statement of purpose was provided in a young person friendly version and in a welcome booklet. Inspectors recommend that a booklet is developed to provide written information for parents, families and significant others. This must include the complaints policy and procedure.

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.

Inspectors found that while there was a range of systems in place to assess and benchmark the centre against the National Standard for Children's Residential Centres, 2018 (HIQA) that these systems were not effective. The centre manager prepared monthly reports which were reviewed by a senior manager with responsibility for the centre and sent to the director of care. Inspectors were shown a comprehensive cloud based shared drive whereby people within the organisation could access and review information appropriate to their role and responsibility. This will facilitate effective communication and planning for young people. The senior area manager conducted regular visits to the service and a review of their management folder evidenced that they were reviewing records on site and providing direction and guidance to the manager. There was evidence of email correspondence relating to day to day practice and implementation of young people's plans. The senior area manager attended the handovers and team meetings both in a planned and responsive way. There was evidence that they had oversight of aspects of care provision and operations in the centre and had highlighted some deficits including issues of safeguarding and child protection and the supervision of staff. They highlighted when information was missing from reports and set out improvements required at team meetings. It was noted that a post incident review was not conducted in a timely manner after a very serious incident and staff stated that debriefings were not formally recorded. The senior area manager had devised a performance improvement plan with the centre manager and had identified some areas requiring improvement but the actions did not fully correlate to all issues noted. While there was evidence that the external consultant was supporting the performance development of the social care manager there was no evidence of organisation performance management discussions at senior management level. Complaints were not recorded in line with the organisational policy to facilitate review of all levels of complaints and feedback for tracking purposes and to promote improvements.

Inspectors found that two audits of the centre by the quality assurance team had taken place since February 2019. One was based on premises and safety and took place in November 2019. A completed action plan was provided to inspectors. A second audit stated to be based on all themes of the 2018 National Standards for Children's Residential Centres 2018 (HIQA) was conducted in June 2020. While this audit covered many aspects of the stated standards it was not clear how it was benchmarked against the themes and features set out in the standards. Inspectors found that the report did not cover all themes as stated but did review some aspects of themes 2, 3, 5 and 6. The methodology/audit framework was not clear. Notwithstanding that, the audit did identify address areas of non-compliance and made 24 recommendations requiring action. Some of these related to discussions relating to child protection and complaints in team meetings and supervision, staff induction, team meetings and follow up to inspections and internal audit processes. One of the recommendations stated that the director of care and the service manager should reflect on and revise accordingly governance arrangements and practice in the centre. While there were notes and ticks on the list of recommendations no completed action plan was provided and some issues requiring attention then also arose during this inspection process.

Inspectors understood that the senior area manager was to conduct monthly themed audits in the centre however only one of these based on planning for young people (March 2020) was evident during this inspection.

Compliance with Regulation	
Regulation met	**Regulation 6.1** **Regulation 6.2**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 5.1** **Standard 5.2** **Standard 5.3**
Practices did not meet the required standard	**Standard 5.4**

Actions required:

- The registered provider must ensure that the centre is operated in compliance with all relevant regulations and national standards.
- The director of care must ensure that all operational policies and procedures are up to date and in line with regulatory requirements taking account of national standards and guidelines.
- The director of care must ensure that internal audits of the service are benchmarked against relevant legislation and all aspects of national standards and that all deficits or gaps in compliance are addressed without delay. These audits must take place in line with organisational policy.
- The director of care must ensure that staff understanding and implementation of policies in practice is assessed and reviewed on an on-going basis with appropriate follow up at senior management level.
- The registered provider must ensure that there is an adequate response and full implementation of actions emanating from all inspection processes within the organisation.
- The director of care must ensure that management meetings take place in line with policy and that they are recorded in a format which reflects discussions, and facilitates tracking of actions and follow up.
- The director of care must ensure that complaints and child protection are standing agenda items at meetings and that an effective escalation process is built in to centre policies.
- The senior area manager must ensure adequate oversight of centre records and registers and take action to address any gaps or deficits.
- The director of care must ensure that there are procedures within the Covid 19 policies and protocols to seek medical advice as to whether a referral for a test is warranted when young people are symptomatic.
- The social care manager must ensure that protocols for the management of Covid 19 are consistently implemented in the centre.
- The director of care must ensure that there is a written model of care which is evidenced based, reflected in the statement of purpose, fully understood by all staff and implemented in practice in the centre.
- The director of care must ensure that the statement of purpose is reviewed and in line with the requirements of the National Standards for Children's Residential Centres, 2018 (HIQA).

Regulations 6 Person in Charge
Regulation 7 Staffing

Theme 6: Responsive Workforce

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

Inspectors found that there were sufficient numbers of staff with the required qualifications, experience and competencies with regard to the number and needs of the children and the statement of purpose. There was a core staff team and no evidence of moving staff between centres or a reliance on agency staff. The organisation had regularly undertaken workforce planning and has a backup of relief staff to cover periods of annual leave or sick leave. This was to ensure that young people were cared for in as much as possible by people who know them and that they are familiar with.

When one young person transitioned to this centre a number of the staff and management team came with them ensuring that they had familiar people available to them. There was evidence at senior management meetings that a number of measures were in place to promote staff retention and continuity of care for young people. Staff exit interviews took place and were discussed at senior management level although it was not clear how the review of this information informed approaches to recruitment and retention of staff. Senior management reported that support measures were in place with the amalgamation of two teams to promote staff stability in the centre. These included staff connect meetings with the director of care which had recommenced following a gap, and the services of an external consultant to support the transition.

The staff roster took account of the skills and experience on the team and wherever possible there was a social care leader on shift. There was an on call system in place which adequately provided for support and cover during evenings and weekends.

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

In general, there were robust recruitment measures in place and staff members were interviewed by two people prior to appointment with detailed notes of the process recorded. Inspectors found that the staff recruitment policy was dated 2016 but did not reference the National Vetting Bureau (Children's and Vulnerable Person's Act 2012 – 2016). Some re-vetting for staff was slightly outside the timeframes identified as organisation policy by senior management. The director stated that the policy would be updated to bring it into line with national requirements. Inspectors found that there was a process in place in the 2016 policy to conduct a risk assessment on file if a disclosure arose through the Garda vetting process. One staff file did not evidence follow up/exploration in respect of gaps in their curriculum vitae in line with the organisation's policy.

All the staff team held a recognised qualification in social care or a relevant qualification. The centre manager was appropriately qualified and was nine years employed with this organisation. Each staff member had a signed contract of employment and job description. Inspectors noted that the personnel files were well organised and had been audited for compliance with regulations through internal governance systems although issues above were not identified during a recent audit.

Review of the organisation's policies and procedures evidenced a written code of conduct contained within the updated child protection policy.

Standard 6.3 – The registered provider ensures that the residential centre supports and supervises their workforce in delivering child-centred, safe and effective care and support.

There was evidence that the staff team were familiar with guiding policies and procedures of the service, however immediate action was required to ensure these policies were up to date, relevant to current legislation and embedded in practice as outlined previously in this report. Policies which were being updated were being communicated to the staff team through training modules and there was some evidence that they were being discussed at team meetings and management meetings. There was a reporting structure with clearly identified line management responsibility and accountability.

There was evidence in keyworking records and in young people's plans that the staff team were able to exercise professional judgement and they were supported to use their initiative in their work with the young people. The regular format for team meetings had stopped in March 2020 and in its place daily handover meeting was extended by 30 minutes. The communication book was also used to convey important information from management and between the team. Some staff interviews and returned questionnaires felt that the current format of team meetings due to the COVID 19 pandemic was not adequate compared to the previous frequency and length of meetings although efforts were being made to ensure that there was reflective practice and good communication.

Staff described handover meetings as supportive forums where staff members were held accountable for their work particularly with the introduction of a new shift assignment plan. This was a comprehensive document which held staff accountable for their work and assisted tracking of assigned tasks. Inspectors found that that while this aspect of handover was effective and efficient there were deficits in recording what information was passed over from the previous shift and this should be reviewed.

There was a risk management framework in place and measures were put in place to mitigate any risks to staff if they were identified. This included measures such as 2:1 staffing or review of placements with social work teams if there was a high level of assaults and property damage in the centre.

There was an organisational approach to professional development and learning. The staff team were supported avail of learning opportunities and the clinical team was available to support staff and guide practice. While staff stated that reflective practice was encouraged and supported this could be better evidenced in supervision and team meeting records.

From review of interviews and returned questionnaires staff were satisfied that there was effective communication within the centre.

Inspectors reviewed staff supervision from July 2019 to August 2020. Inspectors found that while some supervision had taken place in line with policy much of it fell outside the required timeframes. For example, there was no supervision recorded in December 2019 when a total of 118 SENs took place in the centre and, while it is acknowledged that time for supervision is difficult to schedule in a crisis, it is when it is most needed. Some staff had not received supervision since the amalgamation of

the two social care teams despite there being evidence that this issue was a cause of anxiety for staff. Inspectors found there to be some discrepancy in respect of the supervisor/supervisee contract and process. The service must ensure that supervision practice is in line with policy and that each staff member has a contract/supervision agreement with one supervisor. An internal audit by the senior area manager in respect of the social care manager's supervision of their team in January 2020 identified that supervision was not taking place within the timeframes set in policy and that the records were incomplete. This is a recurring issue in both internal audits and inspection processes. The June 2020 audit by the quality assurance team did not identify any practice issues relating to supervision or appraisal as set out in theme 6 of the national standards. A personal improvement plan for the social care manager had been implemented and a supervision schedule put in place with support from the external consultant. However, inspectors found that the follow up to this was not adequate and supervision remained an issue requiring attention at the time of inspection. While supervisors had been trained in the delivery of supervision, training for supervisees was not yet in place and must be implemented to comply with requirements of the National Standards for Children's Residential Centres, 2018 (HIQA).

Inspectors found that there was no operational system in place for annual review of each staff member's performance through a formal appraisal process. Some staff understood that this was in place and had completed appraisal forms but these were not followed up with meetings or agreed actions. Others stated that appraisals had not taken place in a long time but did place a value on them. The 2016 policy for continuous professional development included an appraisal process however inspectors were informed by the social care manager that it was under review as it was not deemed to be beneficial.

There was an employee assistance programme place for staff who required additional support.

Standard 6.4 – Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

There was evidence that there was a focus on continuous professional development in the centre. Staff were supported to attend internal and external training programmes and conferences in support of skills development in their work. Staff had received training in the trauma and attachment aspect of the model of care in use across the

organisation. Training was provided in child protection, a recognised model of behaviour management, first aid and fire safety.

There was a training needs analysis and a resourced training plan in place for the coming year. Staff were supported and expected to attend scheduled training. Required refresher training had taken place within the stated timeframes.

There was a policy in respect of new staff being inducted to work in the organisation and the centre. This was evidenced as having been completed on individual personnel files. New staff completed shadow shifts with experienced members of the team before starting full time. An excel database was in place on a cloud based system to record and track all training and professional development.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1**
Practices met the required standard in some respects only	**Standard 6.2** **Standard 6.4**
Practices did not meet the required standard	**Standard 6.3**

Actions required

- The director of care must ensure that the staff recruitment policy is updated as a matter of priority and is in line with current legislation.
- The director of care must ensure that staff vetting takes place in line with organisation policy
- The director of care must ensure that handover records contain sufficient detail of information which was handed over to staff coming on shift
- The director of care must ensure that team meetings take place in line with policy
- The director of care must ensure that supervision take places in line with

organisational policy

- The director of care must ensure that each staff member's performance is formally appraised at least once per year in line with the requirements of national standards.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director of care must review child protection and safeguarding policies in the centre and ensure that they are consistent with Children First: National Guidance for the Protection and Welfare of Children, 2017.	The Service Child Protection Policy, Code of Conduct, Child Safeguarding Statement and Safe Recruitment Policies have been amended and forwarded to Tusla for review. Completed: 13th Oct 2020. CEO Feedback received will be incorporated into the revised policy prior to implementation. Commencing: TBC CEO	When the on-going policy review is completed, service policies will be reviewed and updated no less than once every two years. Commencing: 12th Dec 2020 CEO
	The director of care must ensure that all staff understand their obligations under	Centre Care Teams and Management will be trained and tested on the revised Child Protection and Safeguarding Policy.	Care Team Members and Management will be re-tested on their knowledge of this policy at regular intervals until the Director

	Children First: National Guidance for the Protection and Welfare of Children, 2017.	Detailed Children First Overview Sheets have been developed for display in centres to support a greater understanding of this policy. Completion: 30th Oct 2020. Service Manager Training / Audit	of Care is satisfied that it is fully understood by all care team members and management. Commencing: 30th Nov 2020. Service Manager Training / Audit
	The director of care must take actions to regularly ensure that centre practice is in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017.	Service Management will incorporate additional monthly checks to ensure all care team members and managers have up to date child protection training that is relevant to their role. Both formal and informal checks will be completed with individual care team members on a regular basis within the internal auditing process as well as planned/ unplanned visits to the centre to review ongoing understanding of responsibilities outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017. Ensuring that practice is compliant with same.	The Director of Care will chair a monthly meeting in which open child protection concerns, complaints and child protection training will be reviewed. Any deficits identified in practice will be notified to the Director of Care and addressed immediately. Commencing: 1st Nov 30th November 2020. Director of Care / Service Managers

		Progress checks in respect of open child protection concerns, complaints and Child Protection Policy testing will also be carried out. Director of Care will also review and discuss with individual care team members when conducting connect meetings to satisfy himself that policy and practice requirement are understood fully. Commencing: 19th Oct 2020. Service Manager Training / Audit	
	The directors of care must conduct a review of the incident for one young person in which they were exposed to significant harm.	A Serious Incident Review to include the relevant SW team and GAL has taken place to review this incident. Draft minutes and agreed actions provided to ACIMS. Meeting Date: 16th October 2020 Service Manager / CEO	Serious incident reviews will take place in a timely manner as needed moving forward in line with policy irrespective of any on-going parallel processes. Commencing: 1st October 2020 Director of Care.
	The services manager must review the processes for communication and cooperation for multiagency and multidisciplinary activity (to	A meeting took place between PSW, GAL, Senior Manager NPPT and CEO to ensure effective cooperation and communication moving forward on this case. Meeting Date: 8th October 2020	Issues of communication or cooperation will be addressed directly and with a view to resolution moving forward. Commencing: 1st October 2020 Director of Care / Service Managers

	include the management of complaints) and ensure that all professionals can work together in the interests of young people.	CEO / PSW / GAL / SM NPPT A meeting took place to review one young person's Programme of Care to ensure all aspects of same are agreed and implemented moving forward. Draft copies of Programme of Care provided to ACIMS. Meeting Date: 16th October 2020 CEO	
5	The registered provider must ensure that the centre is operated in compliance with all relevant regulations and national standards.	A Service Manager with responsibility for quality assurance, has developed a schedule of unannounced full themed audits across all centres. Utilising our all themes audit tool which is based on The National Standards for Children's Residential Centres the service manager will review compliance with all relevant regulations and national standards. A new Service Manager and Centre manager have been appointed to ensure robust	The Director of Care in conjunction with Service Manager will receive verbal feedback following an internal audit. The Director of Care will review all internal audit reports and ensure that any identified deficits or gaps are addressed and rectified as a matter of priority. Commencing: 1st November 2020 Director of Care /Service Manager

		governance is in place and compliance adhered to.	
	The director of care must ensure that all operational policies and procedures are up to date and in line with regulatory requirements taking account of national standards and guidelines.	A Board Meeting will be held to review completed policies with a view to ensuring the centre is operated in compliance with all relevant regulations and standards. Meeting Date: 12th December 2020. Board Members / CEO The policy redevelopment on-going is being prioritised for completion. Completion: 11th December 2020 CEO / HR Manager	When the policy review on-going is completed, service policies will be reviewed and updated as required and no less than once every two years. Commencing: 12th Dec 2020 CEO
	The director of care must ensure that internal audits of the service are benchmarked against relevant legislation and all aspects of national standards and that all deficits or gaps in compliance are addressed without delay. These audits	The overview audit template developed in 2020 will be amended to reflect all themes. Completion: 23rd Oct 2020. Service Manager Training / Audit Both Tusla registered centres will be audited using the revised template. All deficits and gaps in compliance will be	Further changes to the National Standards or associated regulations will be reflected in the audit tools used to monitor them. Commencing: 11th Dec 2020. Service Manager Training / Audit

	must take place in line with organisational policy.	addressed and overseen by Service Manager. Commencing: 2nd November 2020. Service Manager Training / Audit	
	The director of care must ensure that staff understanding and implementation of policies in practice is assessed and reviewed on an on-going basis with appropriate follow up at senior management level	Care teams and managers will be re-tested at regular intervals to ensure all new policies are fully understood and being implemented without exception. Progress and/or issues arising will be reported to the Service Manager and Director of Care at the above referenced meeting to be addressed. Commencing: 30th November 2020. Service Manager Audit / Training	Care Team Members and Management will be re-tested on the policy by the Service Manager with responsibility for training will carry out testing at regular intervals until satisfied that the revised service policies are fully understood by all care team members and management. Commencing: 30th November 2020. Service Manager Training / Audit
	The registered provider must ensure that there is an adequate response and full implementation of actions emanating from all inspection processes within the organisation.	The Director of Care will present inspection / audit action plans implementation to the Board Meetings. Commencing: 12th December 2020 Board / Director of Care / CEO	The Director of Care will present inspection / audit action plan implementation to all future Board Meetings. Commencing: 12th December 2020 Board / Director of Care / CEO

	The director of care must ensure that management meetings take place in line with policy and that they are recorded in a format which reflects discussions and facilitates tracking of actions and follow up.	Centre Manager Meetings will recommence by video link and will be held on a monthly basis. A record of decisions and actions will be maintained and made available for inspection / audit purposes. Commencing: 12th October 2020 Director of Care / Centre Management	In-person Centre Management Meetings will recommence as soon as COVID – 19 is no longer a threat to the health of participants and to the continuing governance of centres. Commencing: TBC Director of Care
	The director of care must ensure that complaints and child protection are standing agenda items at meetings and that an effective escalation process is built in to centre policies.	As stated, Service Management will carry out progress checks in respect of open child protection concerns and complaints on a monthly basis. Commencing: 19th October 2020. Service Manager	As stated, the Director of Care will conduct a monthly meeting in which open child protection concerns, complaints and child protection training will be reviewed. Any outstanding child protection concerns will be addressed by the Director of Care with the Social Work Department responsible for the young person in question for resolution. Commencing: 30th November 2020. Director of Care / Service Managers
	The senior area manager must ensure adequate oversight of centre records and registers and take action to address any gaps	The newly appointed service manager will carry out centre checks to include centre records and registers on a monthly basis. Any outstanding gaps or deficits will be	The Director of Care will follow up on all centre checks with Service Managers on a monthly basis. Commencing: October 2020

	or deficits.	addressed and rectified. Commencing: 1st October 2020. Service Manager	Service Manager / Director of Care
	The director of care must ensure that there are procedures within the Covid 19 policies and protocols to seek medical advice as to whether a referral for a test is warranted.	All possible COVID-19 infections are immediately referred to the relevant young person's GP and also Public Health for advice and guidance as advised in company COVID-19 memos. Commencing: 9th Oct 2020 Centre and Service Managers / Director of Care	Centre Managers are required to maintain a COVID Diary that is used to record all actions they have taken on a daily basis to promote, support and encourage best practice in relation to COVID-19. This includes recording their efforts to address non-compliance. Service Managers to include this diary in their monthly checks. Commencing: 9th Oct 2020 Centre and Service Manager.
	The social care manager must ensure that protocols for the management of Covid 19 are consistently implemented in the centre.	The Social Care Manager will ensure that all protocols relating to COVID-19 are implemented fully in the centre. This will be evidenced in a newly implemented COVID-19 Diary that is maintained by all Social Care Managers and is routinely checked by Service Managers. Commencing: 9th October 2020	See above.

		Centre and Service Managers	
	The director of care must ensure that there is a written model of care which is evidenced based, reflected in the statement of purpose, fully understood by all staff and implemented in practice in the centre.	The revised, evidence-based model of care will be provided to the Board for approval. Forward date: 12th December 2020. Board Members / CEO	The Board will incorporate a review of the service Model of Care into its annual schedule. Commencing: 12th December 2020 Board
	The director of care must ensure that the statement of purpose is reviewed and in line with the requirements of the National Standards for Children's Residential Centres, 2018 (HIQA).	The centre Statement of Purpose will be updated in line with the requirements of the National Standards (and will be further updated when the revised service Model of Care is approved by the Board) Completion: 18th December 2020 Service Manager	All Centre Statements of Purpose will be scheduled for review on an annual basis. Commencing: 1st October 2020 Director of Care
6	The director of care must ensure that the staff recruitment policy is updated as a matter of priority	The Service Safe Recruitment Policy has been updated and forwarded to Tusla for review.	An unannounced audit of one centre will take place on monthly basis to ensure personnel records held in centres, incl.

	and is in line with current legislation.	Completed: 13th Oct 2020. CEO	vetting and training, are complete and up to date. Commencing: 30th November 2020. Service Manager Training / Audit
	The director of care must ensure that staff vetting takes place in line with organisation policy	All recruitment will take place in accordance with the above policy. Completed: 13th Oct 2020. CEO / HR Manager	Service Management will incorporate specific monthly checks to ensure the shift transfer process is being carried out correctly. Commencing: 1st November 2020 Service Manager
	The director of care must ensure that handover records contain sufficient detail of information which was handed over to staff coming on shift	The Shift Transfer process facilitates effective communication between shifts and will be implemented fully and correctly moving forward. Information received verbally will be recorded in that day's diary. Commencing: 6th October 2020 Centre Manager	In-person, full team meetings will recommence as soon as COVID – 19 is no longer a threat to the health of participants and to the continuing running of centres. Commencing: TBC Director of Care

	The director of care must ensure that team meetings take place in line with policy	Restricted team meetings will continue to take place on a daily basis involving Centre Management, oncoming and outgoing care team members. A video-link team meeting will also be held on a monthly basis and will include the relevant Service Manager. Commencing: 30th October 2020 Centre Manager / Service Manager Centre Manager / Service Manager Due to restriction team meetings will continue to take place on a daily basis involving Centre Management, oncoming and outgoing care team members. A video-link team meeting will also be held on a monthly basis and will include the relevant Service Manager in line with current governance structures. A governance policy will be developed as part of organisational policy review	In-person, full team meetings will recommence as soon as COVID – 19 is no longer a threat to the health of participants and to the continuing running of centres. Commencing: TBC

		Commencing: 30th October 2020 (meetings) Centre Manager / Service Manager Completion: 31st December 2020 (Policy) CEO	
	The director of care must ensure that supervision take places in line with organisational policy	Supervision contracts will be put in place and all outstanding supervision will be completed by Centre Management. Completion: 30th October 2020 Centre Manager / Service Manager. Regular auditing will take place to ensure that supervision takes place in line with policy'. A supervision contract has been put in place in supervision with the new Service Manager. Commencing: 9th October 2020 Centre Manager / Service Manager	Where any Deputy / Centre / Service Manager does not carry out supervision at least every eight weeks they will automatically be referred to a workplace review with the Director of Care. Commencing: 9th October 2020 Centre Manager / Service Manager
	The director of care must ensure that each staff member's performance is formally	The revised performance appraisal policy is due for completion and all care team members and managers will have a	Performance Reviews will be scheduled to take place every November using the revised policy and format on annual basis moving

	appraised at least once per year in line with the requirements of national standards.	performance review this calendar year. Completion: 31st October 2020 (Policy) 31st December 2020 (PR) Centre Manager / Service Manager / HR Manager	forward. Commencing: November 2020 Director of Care