An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 118

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Harmony Residential Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**02nd, 03rd, 04th & 11th November 2021**
Registration Status:	**Registered from the 09th September 2019 to the 09th of September 2022**
Inspection Team:	**Lorraine Egan** **Cora Kelly**
Date Report Issued:	**13th June 2022**

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 determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 09th of September 2016. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from the 09th of September 2019 to the 09th September 2022.

The centre was registered to provide medium to long term residential care for four young people aged 13 to 17 upon admission. The model of care was described as being informed by the principles of cognitive behaviour therapy delivered through a therapeutic relationship. The team aimed to meet a number of the young person's needs, primarily the need to feel safe and to build the young person's self-esteem and confidence and to provide more appropriate skills to express their feelings. There were four young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make. This inspection was examined under the interim protocol. During the course of the inspection, it was expanded to include Theme 3: Safe Care and Support, Standard 3.1 only.

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 15th December 2021. 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 29th December 2021. This was not deemed to be satisfactory, and the inspection service requested that a further review of the CAPA be undertaken with an agreed CAPA finalised and received by the inspection and monitoring service on 21st February 2022. The centre management and registered proprietors were informed on the 22nd March 2022 of the decision by the Committee to propose to attach a condition to the centre's registration. The registered proprietors submitted representations on this proposal and a review of the representations was conducted. An onsite visit took place on the 26th May 2022 and the recommendation following this review was that the condition would not be attached to the centre's registration.

The findings of this onsite review deem the centre to have now come into compliance and to be operating in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 118 without attached conditions from the 09th September 2019 to the 09th of September 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

There were four children living in the centre at the time of the inspection and the care plans were not up to date for three of the four children. For two children, child in care reviews had taken place within the previous month and the updated care plans had not yet been received. There was evidence of a care plan request from the centre to one social worker where there was a delay in receiving it following their child in care review. In general, there was a significant gap from once a statutory review meeting took place to the time it took for an updated plan to be provided by the social work department. Further, one child had four different social workers allocated to them since their admission less than two years previously. These issues were not identified as part of centre audits and failed to be escalated by senior management to Tusla social work departments. Inspectors did not observe evidence of a protocol in place for escalation of these deficits. Social workers interviewed were not able to provide satisfactory reasons for these delays or for the frequent changes to placing social workers. Centre management must ensure that centre audits identify deficits on children's files and where there are delays in receiving children's care plans, that these are requested from social work departments in a timely way. A procedure must be developed for escalation of these deficits.

While the care plan that was in date for one child reflected their goals and needs, the proposed actions to support how the plan would be implemented by the social worker and the centre was not detailed. Further, there was no evidence that the correlating strategies put in place by the staff team were effective in responding to the high-risk behaviours current at that time. Communication with social work departments was regular and supplementary multidisciplinary meetings and special reviews were being held between centre management and social workers. These aimed to assess the specific placement concerns along with reviewing the effectiveness and progression of the interventions in place. However, in general, they failed to prevent or manage the ongoing problematic and significant events occurring in the centre which impacted the safety and care of the children placed there. There were a number

of 'placement at risk' meetings arranged with social work departments at certain crisis points for one young person including one where the allocated social worker enquired if the placement was becoming unsustainable but despite this, centre management did not agree, and the young person's placement continued. Social workers stated that they were satisfied with the approaches and interventions in use by the centre staff and some noted there were periods of de-escalation in behaviours at certain times. However, notwithstanding the various increases of sexualised behaviours, inappropriate relationships and bullying interactions between peers, they believed the placement was progressing positively. This feedback was incongruent with inspectors' findings. From their review of centre files including a number of significant event notifications, the strategies and protocols followed in practice by the staff team, failed to reduce the serious incidents occurring and lessen the impact of the problematic behaviour on children in the centre. Consequently, the staff team were unable to adequately protect children in their care. This will be discussed further below. Centre management must ensure that actions and interventions implemented in practice by the staff team are appropriate to the level of high-risk behaviours and significant incidents that are occurring in the centre.

Centre records showed that children and parents/guardians were encouraged to participate and provide their input and opinions to the child in care reviews either by being in attendance or consultation with social workers prior to the meeting.

Placement plans reviewed by inspectors varied in quality. There was an absence of detail regarding actions and tasks to be implemented that were linked to children's goals from their care plans and some were not realistic or achievable given the behaviours that were occurring between peers. Clarity was required regarding who was responsible to ensure that needs identified were being met, with all the staff team being assigned responsibilities rather than conjointly with keyworkers and social workers. There was a deficit in the integration of the placement plans with associated risk management support plans and the individual practice guidelines and there was an absence of internal clinical guidance reflected on the plan. Reviews and updates occurred monthly, with an 'outcomes' section identified for each area of need. In general, there was a lack of evidence demonstrated on how outcomes were being tracked and achieved. Team meeting were taking place every three weeks and minutes reviewed by inspectors did not reflect discussions on placement planning. Contributions by children in meeting their own goals were not consistently taking place through key-working and individual sessions, consequently their voice and preferences were not well represented. While there was a good emphasis in the centre on communication and involvement with children's families particularly in terms of

access, their contributions to their children's care were not recorded in the placement plan. Centre management must ensure that actions on placement plans are clear and realistic and those responsible for their completion to be named. A link to the guidance from the agencies clinical team and risk management support plans should be evident and outcomes consistently tracked. Team meeting minutes should reflect clearly any discussions taking place on children's placement planning. Centre management must ensure that children are involved in the development of their own goals within the placement planning process.

Children had been referred to some specialist services including the Child and Adolescent Mental Health Service (CAMHS) and a youth drug and alcohol agency which had been identified as part of their care planning. In addition, a number of assessments were ongoing for two children with recommendations imminent. Therapeutic direction and guidance were provided by the organisation to the staff team from a counselling psychologist and a behavioural therapist. Centre management told inspectors that weekly reports, key working records and significant event notifications (SEN's) were submitted to the clinical team for their direction and contribution to the centre's support plans and strategies when working with children. Inspectors noted evidence of this input on some centre files, however, the practical instruction received by the centre was not robust and failed to be effective in preventing or reducing the high-risk behaviours occurring in the centre or mitigating the impact on vulnerable children living there. There was an absence of discussion by the staff team on the clinical guidance provided at team meetings. The director of social care and centre manager must review the clinical guidance provided by the services clinical team to ensure that their input is effective in addressing the high-risk behaviours and complex needs of children placed in the centre.

Social workers stated that there was consistent communication to them from centre management including regular updates, weekly reports and they also received SEN's. Inspectors found evidence that the staff team followed direction provided by the placing social workers from decisions made at the multidisciplinary meetings. However, as stated above, these strategies did not affect consistent positive change in the incidents occurring in the centre and social worker's feedback on placement progression for children living there was in contrast to the inspectors' findings. In addition, a management audit highlighted that a number of SEN's had not been submitted to social workers during the Tusla cyber-attack period and it was unclear on records if these had been forwarded by post since this time. Inspectors noted a previous regional manager identifying how notes recorded by staff on centre files constituted SENs, but staff were not directed to submit them as such retrospectively

to the appropriate professionals. The director of social care and the centre manager must ensure that all SEN's are forwarded to the appropriate professionals promptly and in line with statutory requirements. Audits should highlight if actions required on any deficits identified during monitoring are completed.

Compliance with Regulation	
Regulation met	**Regulation 17**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 2.2**

Actions required

- Centre management must ensure that centre audits identify deficits on children's files and where there are delays in receiving children's care plans, that these are requested from social work departments in a timely way. A procedure must be developed for escalation of these deficits.
- Centre management must ensure that actions and interventions implemented in practice by the staff team are appropriate to the level of high-risk behaviours and significant incidents that are occurring in the centre.
- Centre management must ensure that actions on placement plans should be clear and realistic and those responsible for their completion to be named.
- The director of social care and centre management must ensure that links to the guidance from the agencies' clinical team and risk management support plans should be evident across placement planning. Outcomes for children must be consistently tracked so as to monitor their progress through the process of placement planning.
- Centre management must ensure that team meeting minutes should reflect clearly any discussions taking place on children's placement planning.
- Centre management must ensure that children are involved in the development of their own goals within the placement planning process and that their family's input is recorded.
- The director of social care and centre manager must review the clinical guidance provided by the services clinical team to ensure that their input is

effective in addressing the high-risk behaviours and complex needs of children placed in the centre.

- The director of social care and the centre manager must ensure that all significant event notifications are forwarded to the appropriate professionals promptly and in line with statutory requirements. Audits should highlight if actions required on any deficits identified during monitoring are completed.

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

Inspectors found that child safeguarding policies and procedures were in place in the centre and regularly updated by a policy core group in the organisation which included centre and senior managers. While the policy was in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the relevant legislation, some amendments are required relating to the mandatory reporting procedures and reporting protocols under 'reasonable grounds for concern'. In addition, the definitions of abuse should be updated to be aligned to the most recent guidance. Staff had received training in the Tusla E-Learning module: Introduction to Children First, however there were deficits in the provision of child protection training based on the centre's policy and this must be provided by the organisation. There was some indication that centre policy and procedures were part of team meeting agendas, but inspectors did not observe evidence of discussions of the child safeguarding policy including the child safeguarding statement on records sampled, nor was there consideration of current child protection concerns. The centre had received a letter of compliance for their child safeguarding statement from the child safeguarding statement compliance unit. The director of social care and centre management must ensure that amendments that are required relating to the centre's child safeguarding policy are completed. All staff must receive training on the centre's policy and updates must be discussed and shared with all members of the staff team.

There was a policy in respect of bullying and harassment and this formed part of the child safeguarding suite of policies. However, inspectors found there was a very high threshold in place before bullying behaviour incidents were required to be reported as child protection and welfare concerns. One of the social work departments

confirmed with inspectors that decisions regarding what concerns were to be reported was done in consultation with them. The director of social care and centre management must revise the centre's bullying threshold protocol. Inspectors found evidence that bullying and harassment, sexualised interactions and incidents, physical threats and on occasion assaults were a feature between some young people living in the centre for a prolonged period of time. Interventions and strategies implemented to mitigate the bullying incidents were not robust enough including staff ratios and were not managed appropriately by the centre so that the children could not be protected and kept safe together. Behaviours of concern identified on pre-admission risk assessments (PARAs) were not given adequate consideration when deciding on the suitability of the placement for children being admitted as well as for those already living there. From the information contained in children's PARA regarding specific problematic behaviours and complex needs, inspectors determined that some of this cohort of children should not have been placed together. Two of the children living in the centre had learning difficulties and one was cognitively operating at a much younger age than they presented. This diagnosis required robust interventions, supervision and support to keep them safe within their peer group.

Inspectors reviewed the complaints register and noted that the number of complaints by children regarding the bullying incidents did not correlate with the substantial incidents of bullying taking place in the centre. Records described how some children were experiencing a lot of anxiety and fear regarding the bullying incidents and highlighted in their questionnaires how they wanted the fighting to stop in the house and were unhappy with the ongoing conflict. Centre management must ensure that strategies and interventions implemented to mitigate bullying behaviours should be strong enough to protect children and keep them safe while living together. The centre must as a learning outcome review their pre-admission procedures and risk assessments to ensure that there is an appropriate evidence-based assessment of need, and that all referral information is thoroughly reviewed and assessed before offering a placement to a young person. Children should be encouraged to make complaints after every incident of bullying behaviour against them.

Where an inappropriate relationship had formed between two children, centre staff did not report the significant number of incidents that occurred as child protection concerns under the centre's policy. These interactions were not identified at an early stage by the staff team until subsequent disclosures took place. Further, the approaches and interventions implemented by the staff team to prevent the behaviours were not effective and records indicated that the centre management and team generally viewed the incidents as being within the context of a normal

relationship. In addition, on centre records and from interviews with staff and the director of social care, there was a tendency to use language that minimised one child's disclosures over another and consequently there was evidence that one child was more supported. There was a failure to report these concerns and respond effectively in line with policy and best practice. These disclosures were not reported under the mandated reporting protocol but referred to the placing social work department who investigated the concerns and subsequently found them to be unsubstantiated. At interview staff could describe the process for mandatory reporting but were unfamiliar with the procedure in place to report concerns that did not meet the mandatory threshold. The director of social care and the centre manager must ensure that the mandatory protocol for reporting disclosures of abuse is followed. Staff must be made aware of what constitutes inappropriate sexualised behaviour and that disclosures of abuse are accepted and responded to for all children in the same way. Child safeguarding training provided to centre staff should include the reporting procedures for reasonable grounds for concern.

While some safeguarding measures and behaviour management approaches outlined in risk assessments and behaviour support plans worked, in general, they were not adequate in addressing the individual areas of vulnerability for children. In addition, there were deficits in the development of safety plans for each high-risk behaviours taking place and incidents were not being monitored and reviewed at team meetings or senior management meetings. While key working was taking place on areas such as self-care, respect for others, consent and risk and consequences, this individual work was not sufficient to be supportive or to have helped children to develop the knowledge, self-awareness, understanding and skills needed which was aligned to their stage of cognitive development. Placing social workers were aware of the significant incidents taking place and provided advice and direction to the centre, however, this guidance failed to promote the safety and well being of children living there. The centre manager must ensure that safety plans identify individual areas of vulnerability for each high-risk behaviour taking place. Incidents should be monitored and reviewed for learning purposes. Key working taking place should be comprehensive and robust in areas such as self-awareness and self-care and protection.

There was a whistle blowing/protected disclosures policy in place and staff were aware of who to report to should they need to pass on a concern without adverse consequences to themselves.

Compliance with Regulation	
Regulation not met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 3.1**

Actions required

- The director of social care and centre management must ensure that amendments that are required relating to the centre's child safeguarding policy are completed. All staff must receive training on the centre's policy and updates must be discussed and shared with all members of the staff team.
- The director of social care and centre management must review the threshold in place for reporting bullying and harassment incidents as part of child protection and welfare concerns.
- Centre management must ensure that strategies and interventions implemented to mitigate bullying behaviours should be strong enough to protect children and keep them safe while living together.
- The centre must as a learning outcome review their pre-admission procedures and risk assessments to ensure that there is an appropriate evidence-based assessment of need, and that all referral information is thoroughly reviewed and assessed before offering a placement to a young person. Children should be encouraged to make complaints after every incident of bullying behaviour against them.
- The director of social care and the centre manager must ensure that the mandatory protocol for reporting disclosures of abuse is followed. Staff must be made aware of what constitutes inappropriate sexualised behaviour and that disclosures of abuse are accepted and responded to for all children in the same way. Child safeguarding training provided to centre staff should include the reporting procedures for reasonable grounds for concern.
- The centre manager must ensure that safety plans identify individual areas of vulnerability for each high-risk behaviour taking place. Incidents should be monitored and reviewed for learning purposes. Key working taking place should be comprehensive and robust in areas such as self-awareness and self-care and protection.

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

Theme 5: Leadership, Governance and Management

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

The centre manager had been in their position for over two years and had worked in the centre for four years. They were the person in charge with overall executive accountability and had authority and responsibility for the delivery of the service in the centre. They were supported in their role by a deputy manager and a social care leader.

The centre manager worked from 9 a.m. to 5 p.m. Monday to Friday and attended team meetings, internal management meetings, senior management meetings and provided some supervision. There were also present at child in care reviews, handovers and multidisciplinary and strategy meetings. Staff interviewed said they were supportive as a manager to them as team members. However, inspectors found that there was a deficit in the lines of authority and accountability at middle management level in the organisation. The regional manager's position was vacant for a number of months as they had temporarily taken up a role of acting manager in another centre due to staffing issues. While their former duties and responsibilities had been subsumed into the director of social cares' post, some gaps from the absence of this role were evident regarding governance within the centre. This included oversight on children's files, consistent direction and guidance being provided to the centre manager, significant event reviews were not occurring and there was an omission of regular auditing and monitoring to ensure that delivery of care was child centred, safe and effective in the centre. Further, senior management were not visiting the centre to meet with management, staff and children or to conduct external audits. The centre manager told inspectors that they believed that the current lack of function of the regional manager's post did not negatively impact the care provision to the children living there despite the deficiencies identified by inspectors. The director of social care provided supervision to the centre manager and attended senior management meetings. Due to Covid 19 risks, a decision was made by the organisation to have all meetings taking place online, however, when restrictions were lifted and risks diminished, meetings continued through this

medium without a review taking place. The registered provider must ensure that deficits in governance and management arrangements at regional manager level is addressed and that there are clear lines of accountability at external management level within the organisation. The director of care must ensure regular internal and external auditing is taking place in the centre.

Inspectors found that the centre's risk management system did not adequately identify, assess and manage the high-risk behaviours that had been a feature in the centre and had been reoccurring regularly. While a risk policy and processes had been developed, it was not effective in how it informed the practice being implemented to manage each child's individual risks and vulnerable behaviours so that the care being delivered was not done so in a safe way. The interventions outlined in the risk assessments and behaviour support plans were not always rigorous enough to manage or reduce the behaviours and in most cases the protocols that staff were following were too vague. Consequently, the high-risk behaviours and incidents did not significantly decrease on a consistent basis. Reviews of risk assessment plans were not conducted by the centre's clinical team or senior and centre management and alternative strategies were not identified to mitigate the risks effectively and so children remained vulnerable while placed there. Further, there was an absence of individual safety plans developed in response to respective risks and inspectors found that some high-risk behaviours required specific risk assessments containing a targeted approach and intervention for their management. As referred to above, incidents were not reviewed at team meetings or management meetings for learning purposes, and it was not clear how they were escalated. Further, as stated, the guidance from the clinical team to the risk management framework was not adequate or satisfactorily specific to the individual child. Certain vulnerabilities and high risks identified on pre-admission risk assessments were not adequately prioritised when being assessed and there were no risk registers in place. All of the team were not fully trained in the centre's behaviour management approach in operation in the centre. The director of social care and centre management must review the risk assessment policy and related practices. They must ensure that the risk management framework and supporting systems in place adequately identifies, assesses and manages all high-risk behaviours. The interventions outlined in supporting plans must be robust, individualised and have clear guidance outlined for staff to follow and implement in practice. Risk registers must be developed and implemented in the centre.

An appropriate service level agreement was in place with Tusla, and evidence was provided to them as the funding body of its compliance with relevant legislation and the national standards.

Operational policies and procedures were reviewed annually. The most recent review having taken place in February 2021. As referred to above, updates to procedures were completed as required throughout the year and inspectors saw evidence that a number of amendments had been applied to policies such as child safeguarding, on call, bullying and harassment and the employee handbook.

There were alternative management arrangements in place where the deputy manager deputised when the centre manager was absent. Specific roles of the deputy manager and social care leader were outlined as part of the centre's internal management team's responsibilities. However, there must be a written record of specific tasks maintained with key decisions made where duties are delegated by the centre manager to appropriately qualified staff members.

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

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

Actions required

- The registered provider must ensure that deficits in governance and management arrangements at regional manager level is addressed and that there are clear lines of accountability at external management level within the organisation.
- The director of care must ensure regular internal and external auditing is taking place in the centre.
- The director of social care and centre management must review the risk assessment policy and related practices. They must ensure that the risk management framework and supporting systems in place adequately

identifies, assesses and manages all high-risk behaviours. The interventions outlined in supporting plans must be robust, individualised and have clear guidance outlined for staff to follow and implement in practice.

- The director of social care and centre manager must ensure that risk registers are developed and implemented in the centre.
- The centre manager must ensure that there is a written record of specific tasks maintained with key decisions made where duties are delegated by the centre manager to appropriately qualified staff members.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

Prior to inspectors going onsite for the inspection, the director of social care informed the ACIMS that there were not sufficient numbers of staff currently working in the centre. They submitted a risk assessment along with a plan to address the staffing gaps. According to the staff information sheet that had been returned to inspectors, there were serious and significant deficits in staffing numbers. The staff complement requirement for the centre should include one manager and a minimum of eight whole time equivalent staff at all times. Only one manager and four full time social care workers were working in the centre at the time of the inspection. One further social care worker was on maternity leave and their line was being covered by a relief panel member. Of the current four full time staff, one of those was transferring to a sister centre and another was moving to the relief panel. Five staff had left their positions between 12th September and 01st November 2021 citing difficulties with live nights and finding the shifts too onerous. Inspectors reviewed the centre rota and found specific gaps, for example, on the second day of the inspection, social care workers from three other centres within the company were placed on duty to ensure there was enough staff on shift for that day. Inspectors were informed by centre management that there was a policy to move staff around between centres in emergency situations. Also, during the inspection process there was an emergency discharge for one young person and thus there was a requirement for staff to be on a rota with them in alternative accommodation during the interim respite period. The director of social care stated that there was on ongoing recruitment drive underway and interviews had taken place for five vacancies and once their files were completed,

they would be onboarded. In the meantime, as a centre within the organisation was closing temporarily, the staff from there would be deployed to complete a full staffing complement on a temporary basis. This would be in place by November 22nd 2021, and would expand the team to include one manager plus eleven social care workers comprising of one deputy manager and three social care leaders. However, inspectors found that none of these arrangements were guaranteed to be accomplished in the immediate future and therefore the staffing deficits were not satisfactorily being addressed by centre management or the director of social care in terms of workforce planning. This had a significant impact on an acceptable standard of care provision and safeguarding for children living in the centre, given the complexities of children's needs, their vulnerabilities and the high-risk behaviours they presented with. Further, as outlined in support plans, there was a requirement for high staff supervision and children not to be left on their own. From a review of rotas and significant incidents, in practice, the centre did not consistently meet this commitment. Staff shortages and workforce planning were discussed at senior management meetings, however responses to the significant inadequacies were not satisfactory. Centre management were responsible for devising the rota. The director of social care must ensure that there are effective organisational workforce planning mechanisms in place to address the significant staffing deficits in the centre and to also prevent the consistent movement of staff between centres within the organisation.

Of the full-time staff team including the manager, four social care workers and one whole time equivalent, three had a social care qualification, two a relevant equivalent and one did not have the required qualifications. These further deficits in staffing qualifications must be resolved by senior management as part of workforce planning. Some arrangements were in place that promoted staff retention including hourly rates of pay, opportunities for career advancement, pension and health insurance options and a formal Employee Assistance Programme. However, as highlighted above, these were not robust enough.

Inspectors observed deficits on personnel files sampled that related to safe recruitment practices including a copy of qualification not on file, absence of a curriculum vitae and a reference not including the most recent employer. In addition, core training was out of date such as first aid, fire safety, behaviour management refreshers and child safeguarding. The director of social care must ensure that safe recruitment practices are in place and that deficits evidenced by inspectors are addressed promptly.

There were procedures in place for on-call arrangements. Centre managers, deputy managers and social care leaders were part of the 10-week system for evenings and weekends. The director of care along with the CEO were available to the team at all times in conjunction with their on-call traffic light process. There was an absence of formalised procedures in place for recording decisions made if the protocol was activated. In addition, the policy informing the practice lacked sufficient detail. The director of care must ensure that procedures for on-call arrangements are outlined in detail in the centre's policy and that formal records are kept when the protocol is in use.

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

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

Actions required

- The director of social care must ensure that there are effective organisational workforce planning mechanisms in place to address the significant staffing deficits in the centre and to also prevent the consistent movement of staff between centres within the organisation. Staff must meet the requirement to be social care qualified or possess a relevant equivalent qualification.
- The director of social care must ensure that safe recruitment practices are in place and that deficits evidenced by inspectors are addressed promptly.
- The director of care must ensure that procedures for on-call arrangements are outlined in detail in the centre's policy and that formal records are kept when the protocol is in use.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	Centre management must ensure that centre audits identify deficits on children's files and where there are delays in receiving children's care plans, that these are requested from social work departments in a timely way. A procedure must be developed for escalation of these deficits.	The centre management team will keep a tracker of items required from the social work department for children's care plan records. The tracker will have a timeframe allocated for follow up/ escalation in line with the escalation policy. This process will allow for the identification of deficits. Internal audits will be completed on the children's care files once a month by the full centre management team on a rotation basis. Any issues arising in either system will be notified by the centre management team to the regional manager to escalate deficits. This is effective as of February 2022.	The Regional manager will meet the deputy manager and centre manager once a month to have a regional management meeting. The purpose of this meeting is to review the CAPA to the centre and also to review any deficits requiring escalation and the process will allow for planning follow up action. In addition to this, the senior quality assurance manager will complete a themed audit under the National Standards 2018 every month in the Centre. The QA report will have an action plan and person responsible identified should any deficits be found.
	Centre management must ensure that actions and interventions implemented in practice by the staff team are appropriate to the level of high-risk	The Centre Management Team when reviewing the risk assessments for high-risk behaviours will clearly evaluate each intervention identified from a practice	The senior management team and centre management team are responsible for ensuring that centre risks, young person risks and organisational risks are

	behaviours and significant incidents that are occurring in the centre.	level to determine the effectiveness and appropriate of same. This process will allow for a behavioural strategy review and any issues arising or an increase in risk will be escalated to line management for further planning. Once a month, risk assessments will be audited and reviewed by the Centre Manager, Deputy Manager and Regional Manager at the Regional Management Meeting. This is effective as of February 2022.	identified, reviewed and treated. The escalation policy is implemented on the identification of new/ escalating high-risk behaviours. Centre visits and centre audits will be conducted by the senior management team. SERG reviews will be directed for completion by the senior management team if not identified by the Centre management team. Reviews and discussions of risk behaviours will also be discussed at management meetings, staff supervisions, SERG reviews and team meetings allowing for a full holistic review and early intervention. In addition, this issue requiring action will remain open and monitored on the Centres risk register.
	Centre management must ensure that actions on placement plans should be clear and realistic and those responsible for their completion to be named.	The centre manager has completed a CPD session with the staff team regarding actions on placement plans and identifying persons responsible for ensuring the completion of those actions. This was completed by the first week in December 2021. In addition, a review of the monthly placement plan template has been	The centre Management team will review the monthly placement plans every month to ensure they are clear and realistic and specific people are identified. The regional manager will audit this once a month at the centre regional management meeting when reviewing the CAPA.

		completed with the team and the monthly placement plan template has been updated to reflect this feedback. This is in effect as of 22nd of December 2021.	
	The director of social care and centre management must ensure that links to the guidance from the agencies' clinical team and risk management support plans should be evident across placement planning. Outcomes for children must be consistently tracked so as to monitor their progress through the process of placement planning.	The monthly placement plan has been reviewed and updated. As of 22nd of December 2021, the new templates have been shared across the organisation. The revised placement plans ensure a direct link to guidance from the clinical team and also risk management support plans. In addition, to ensure a robust review on outcomes for children, the case management template was updated in November 2021 and rolled out to all Centres in December 2021. This document ensures a review of the effectiveness of interventions in place to enable monitoring of progress.	Placement planning will be reviewed monthly by the centre management team ensuring that guidance from services and risk management are evident. Any deficits will be actioned by the centre management team. In addition, the regional manager reviews each child's progress weekly reviewing outcomes and completes oversight and action planning on same.
	Centre management must ensure that team meeting minutes should reflect clearly any discussions taking place on children's placement planning.	Centre management have developed a new record for discussing young people's placement plans at team meetings and to evidence discussions taking place. This has	Centre manager has appointed a rotation of the leaders to take team meeting minutes and the centre manager will review these minutes following each

		been implemented. The keyworkers will prepare the report in advance of the meeting – linking it to the case management meeting and plans. The centre management team completed a CPD session with the team on the 25th of November 2021 regarding this. In addition, the centre manager will complete a further CPD session with the entire team in January 2021 team meeting in relation to recording discussions at the team meeting. These CPD sessions have been shared with inspectors along with this CAPA.	meeting to ensure they reflect discussions clearly. The regional manager will attend a team meeting in the centre once every three months and will review the centre team meeting minutes following her attendance at same. Any feedback required will be prepared by the regional manager.
	Centre management must ensure that children are involved in the development of their own goals within the placement planning process and that their family's input is recorded.	The centre manager has implemented a new record for evidencing clearly that young people and their families are involved in the development of their own goals and planning for same. This was implemented on 22nd of December 2021 and guidance has been given to the team for the implementation of this record. This record will be implemented in full with the January 2022 placement planning process.	The case manager for each child will ensure that these new forms are completed monthly with the children and their families. Centre management team will review that the input from young people and their families are accurately recorded in the monthly placement plan. The senior management team will review placement plans as part of their audits/ meetings which will occur monthly.

		The case management record also ensures this action is completed monthly and allows for the identification of the person responsible for ensuring same. The case manager is responsible for ensuring these are completed monthly by the keywork team. This document has been shared with inspectors along with this CAPA.	
	The director of social care and centre manager must review the clinical guidance provided by the services clinical team to ensure that their input is effective in addressing the high-risk behaviours and complex needs of children placed in the centre.	Clinical team guidance is provided weekly via a clinical team recommendations report. All guidance and interventions identified by the clinical team for implementation will be reviewed by the centre management team weekly. Following this an action plan will be developed weekly and tracked by the centre management team to ensure recommendations are completed. This is in effect as of November 2021 and the centre deputy manager is overseeing this. A review of clinical team recommendations will be evidenced across the monthly placement planning process, case management record and in the team	The regional manager reviews the clinical guidance weekly. In addition, the regional manager is responsible for reviewing the Centre risks escalated to her in line with the revised risk management framework. The effectiveness of interventions will be reviewed by the centre manager, Deputy manager and regional manager in their monthly meetings. Any actions identified will be responded to.

		meetings. These templates have been updated to ensure same and are in effect immediately. As noted above, high risk behaviours presenting for young people will be tracked and reviewed across the new risk management framework. Any escalations will be processed via the young person risk register and/or escalation process, where applicable for further evaluation and risk treatment. This is effective immediately.	
	The director of social care and the centre manager must ensure that all significant event notifications are forwarded to the appropriate professionals promptly and in line with statutory requirements. Audits should highlight if actions required on any deficits identified during monitoring are completed.	All four social work departments have confirmed they have received all significant events for each child where issues arose during the first two weeks of the HSE cyber-attack. With immediate effect, all significant events will be notified via statutory requirements. Where oversight from management identifies a significant event that may not have been recorded on the relevant form, a significant event notification will be completed and shared as soon as possible with social workers and other relevant	The regional manager will complete oversight on all weekly reports/ significant events to ensure that all significant events are identified and sent to the appropriate professionals. In addition, the senior quality assurance manager will complete audits on the children's records. Any deficits will be identified, actioned and monitored until completed. This issue requiring action will be added to the Centre risk register and remain open and under monitoring.

		persons. Centre management and senior management are responsible with immediate effect for reviewing and monitoring that those actions identified are completed.	
3	The director of social care and centre management must ensure that amendments that are required relating to the centre's child safeguarding policy are completed. All staff must receive training on the centre's policy and updates must be discussed and shared with all members of the staff team.	The policy review group will conduct a full policy review on the child safeguarding policy and update all additional supporting child safeguarding documents to ensure the amendments required are completed. This will require a review also on the child safeguarding statements, CPD sessions, young person booklets and parent and social work handbooks. This action will be completed by the end of January 2022 and all updates will be discussed with the team members via a CPD session. Organisational training on children first will also be updated following this review and all employees will receive training relating to the updates.	The director of social care is accountable for ensuring that this action will be completed in full by the end of January 2022. Any updates relating to child safeguarding will be completed by the policy review group and the standing agenda on the management meeting record includes safeguarding and policy reviews. This issue requiring action will be added to the Centre risk register and remain open and under monitoring.
	The director of social care and centre management must review the threshold	The threshold in place for reporting bullying and harassment has been revised	The director of social care is accountable for ensuring that this action will be

	in place for reporting bullying and harassment incidents as part of child protection and welfare concerns.	and changed. Effective immediately, all incidents of bullying and harassment will be reported via the Tusla portal under the process for reasonable grounds or a child welfare concern.	completed in full by the end of January 2022. Any updates relating to child safeguarding will be completed by the policy review group. This issue requiring action will be added to the Centre risk register and remain open and under monitoring.
	Centre management must ensure that strategies and interventions implemented to mitigate bullying behaviours should be strong enough to protect children and keep them safe while living together.	The centre management team will identify, and risk assess any bullying behaviour and evaluate the interventions through risk assessment reviews which will occur as identified in the risk assessment.	Regardless of who is the owner of the risk (centre manager/ regional manager) – risk assessments in the Centre will be reviewed and evaluated monthly at the Regional Centre Management Meeting. If there are concerns regarding child protection or child safety, the escalation process will be implemented immediately.
	The centre must as a learning outcome review their pre-admission procedures and risk assessments to ensure that there is an appropriate evidence-based assessment of need, and that all referral information is thoroughly reviewed and assessed before offering a placement to a young person. Children should be	The pre-admission impact risk assessment currently in place has a risk matrix to ensure that all risk behaviours from low to extreme risk are identified during the pre-admission risk assessment stage of receiving a referral. No child is admitted unless approval is received from the current social workers and placing social	Pre-admission meetings will occur prior to placements being offered at which the young persons' needs will be identified/ discussed with the placing SWD and a plan will be outlined to identify the ways in which the placement can meet the identified needs. The Centre Management team will be responsible for this. The Regional Manager completes oversight on

	encouraged to make complaints after every incident of bullying behaviour against them.	workers. All queries relating to referrals from any social worker are clearly recorded on the pre-admission risk assessment form and shared with all relevant persons. These procedures will continue, however, the new and more robust risk matrix identified during the policy review of the risk assessment policy completed and rolled out on December 17th, 2021, will now be used. In addition, a review of the complaints policy will be completed by the end of January 2022 when the safeguarding policy is being reviewed as complaints form part of the safeguarding policy. However, in the interim, the Centre Manager will discuss this action with the staff team to ensure that the team offer a child a complaint after every incident of bullying. This will be completed by 31.12.2021. The Regional Manager with immediate effect will ensure this action is completed when completing oversight and governance on significant events.	significant events and weekly reports and if there is an instance whereby a complaint has not been identified and offered, then the management team/ regional manager will identify and action same with immediate effect.

	The director of social care and the centre manager must ensure that the mandatory protocol for reporting disclosures of abuse is followed. Staff must be made aware of what constitutes inappropriate sexualised behaviour and that disclosures of abuse are accepted and responded to for all children in the same way. Child safeguarding training provided to centre staff should include the reporting procedures for reasonable grounds for concern.	The DLP is in the process of conducting a full review of child protection concerns that were made within the Centre over the past three months. This review will also focus on any deficits in reporting. Any learning identified will be recorded in the safeguarding report and any actions stemming from this will be actioned. Child safeguarding training in the organisation will be updated the end of January 2022 when the full safeguarding review is completed. In addition, a CPD session is under development at the moment by a Deputy Manager from another Centre and will be implemented across the organisation relating to sexualised inappropriate behaviour. Every staff member will engage in the CPD session. This will be completed by the end of February 2023.	We have revised the Child Safeguarding team to have a DLO and each centre manager will be the DLP. Training for the DLP's will be completed by the end of March 2022. The Child Safeguarding training on the mandatory reporting protocol has been updated and training in this is being rolled out in March 2022 by the Child Safeguarding Trainer and will include an exam to ensure that all attendees have a full understanding of the reporting procedures for reasonable grounds.
	The centre manager must ensure that safety plans identify individual areas of vulnerability for each high-risk behaviour taking place. Incidents	Upon identification of a high-risk behaviour, a risk assessment will be completed and added to the risk register. The Centre Management team will be	The regional manager will engage the Centre Management team in a monthly centre meeting which will include the review of risk assessments and their

	should be monitored and reviewed for learning purposes. Key working taking place should be comprehensive and robust in areas such as self-awareness and self-care and protection.	responsible with immediate effect for ensuring each vulnerability is identified and effectively evaluated during risk reviews. The need for SERG reviews will be identified during centre/ regional management oversight on the incident report forms and completed. Centre management is responsible for same. The required key working has been resourced from the organisation's clinical team and this is included on each child's monthly placement plan and is already in effect. Centre management is overseeing the completion of same.	evaluation. This will be ongoing and monthly to ensure all areas of vulnerability have been identified. Any deficits arising in risk assessments/ key working will be identified and actioned. In conjunction to this, the SQAM is completing monthly centre themed audits and also will engage in action planning.
5	The registered provider must ensure that deficits in governance and management arrangements at regional manager level is addressed and that there are clear lines of accountability at external management level within the organisation.	The Organisation has reinstated the assistant regional manager into a full-time regional manager position as of December 20th, 2021. In addition, the former regional manager will commence a full-time post as a senior quality assurance manager in January 2022. The director of social care will ensure by the end of January 2022 that there is a clear line of accountability via a specific report identifying roles and responsibilities for each member of the	The director of social care is the direct line of management to the regional manager and senior quality assurance manager. The director of social care will ensure monthly senior management meetings occur and that there is clear evidence of planning, accountability and follow up. This issue requiring action will be added to the Organisation risk register and Centre register and remain open and under monitoring.

		senior management team.	
	The director of care must ensure regular internal and external auditing is taking place in the centre.	The regional manager and senior quality assurance manager will meet with the director of social care to develop an annual auditing plan, and this will be completed by January 14th, 2022.	The director of social care will oversee the auditing completed within the Centre in regard to quality assurance auditing and internal auditing. The regional manager and senior quality assurance manager will report directly to the director of social care relating to Centre auditing via evidenced based practice. These will be discussed at senior management meetings. A new standing agenda will be devised by all members of the senior management team once the quality assurance manager commences her post in January 2022. This identified action to compose a standing agenda will be completed by the end of January 2022. This issue requiring action will be added to the Organisational risk register and remain open and under monitoring.
	The director of social care and centre management must review the risk assessment policy and related practices.	Post inspection, in November 2021, a full review of the risk management policy was completed by the senior management	Once a month, risk assessments in the Centre will be reviewed by the Regional Manager. Any deficits will be actioned.

	They must ensure that the risk management framework and supporting systems in place adequately identifies, assesses and manages all high-risk behaviours. The interventions outlined in supporting plans must be robust, individualised and have clear guidance outlined for staff to follow and implement in practice.	team and policy review group. On December 17th, 2021, the new risk management policy and framework has been implemented across the organisation. The new procedures for risk analysis and risk treatment will allow for a more robust review of high-risk behaviours and significant incidents. Risk assessments will be reviewed as required by the owner of risk. These updated documents have been shared with the inspectors along with this CAPA response.	
	The director of social care and centre manager must ensure that risk registers are developed and implemented in the centre.	These were implemented on December 17th, 2021. The Centre manager is currently transferring all information from previous risk registers into the new record and completing new risk assessments based on the new risk documents that are in line with the new risk management framework. By end of January 2022, these will all be finalised in full.	The regional manager will engage the centre management team in a monthly centre meeting whereby a review of risk assessments forms part of this meeting. Whereby there is a deficit identified, this will be actioned.
	The centre manager must ensure that there is a written record of specific tasks maintained with key decisions	The centre manager with immediate effect will ensure that there is a written record in place in to outline the delegation of duties	The line manager to the Centre will review any delegated tasks by the manager on receipt. In the event of an unplanned

	made where duties are delegated by the centre manager to appropriately qualified staff members.	to appropriately qualified staff members. The Centre Manager will also send a record to line management of this record as required, i.e., when the manager is going on annual leave.	absence, such as sick leave the line manager to the Centre, along with the other members of the senior management team will review the duties and make a solid plan to ensure all duties have a specified person responsible for same.
6	The director of social care must ensure that there are effective organisational workforce planning mechanisms in place to address the significant staffing deficits in the centre and to also prevent the consistent movement of staff between centres within the organisation. Staff must meet the requirement to be social care qualified or possess a relevant equivalent qualification. The director of social care must ensure that safe recruitment practices are in place and that deficits evidenced by inspectors are addressed promptly.	The staffing list has been sent to the Alternative Care Inspection and Monitoring Service (ACIMS) along with a centre roster to reflect that the staffing requirements are met. With regards to the movement of staff between centres, this will be avoided where possible. Workforce planning will be a focus of the management meetings and also the senior management meetings. An organisational training matrix has been completed and will remain under live review by the Organisational administrator. The registered providers are planning all required training for the team over January, February and March 2022. Relating to the staff personal files,	Recruitment remains live and ongoing across the organisation. There will be at minimum at least four recruitment drives per annum. As noted above, the regional manager will complete final oversight in regard to shortlisted candidates to ensure they possess the qualification criteria as outlined in the Tusla document. There will be two lines of governance over safe recruitment practices, namely our HR admin and also the regional manager.

		the organisation was in the process of going online with all staff personal information. The regional manager and centre manager will conduct a full audit on each file and follow up on any actions identified. There will be a record relating to this kept on file, in the centre management auditing folder. This audit will be completed by 10th of January 2022. The organisation now has a full-time admin person in role to assist with recruitment procedures and who will oversee the development of staff files on the identification of a new candidate. The admin completes the training analysis for each new candidate.	
	The director of care must ensure that procedures for on-call arrangements are outlined in detail in the centre's policy and that formal records are kept when the protocol is in use.	This action is complete. The on-call policy was reviewed on 14.12.2021 and has been shared across the organisation. In addition, at the same time, a formal record was developed for when the protocol is in use. The new record form has been shared with ACIMS with this CAPA.	The director of social care will keep a formal record of all on-call reports and review same.