An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 163

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Tus Nua Childcare Services**
Registered Capacity:	**4 young people**
Type of Inspection:	**Themed Unannounced**
Date of inspection:	**22nd and 23rd February 2022**
Registration Status:	**Registered with an attached condition from the 24th October 2019 to the 24th October 2022**
Inspection Team:	**Cora Kelly** **Lorraine Egan**
Date Report Issued:	**14th June 2022**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in October 2019. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered with an attached condition from the 15th of June 2021 to the 28th of February 2022:

There will be no further admissions to the centre until such time that the centre is fully compliant with Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 5 *Care Practices and Operational Policies*, that appropriate and suitable care practices and operational policies are in place, having regard to the number of children residing in the centre and the nature of their needs.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was described as the secure base model which has its roots in attachment theory and resilience. There were two children 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
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those

concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

At the time of this inspection the centre was registered with an attached condition from the 24th of October 2019 to the 24th of October 2022. A draft inspection report was issued to the registered provider, centre manager and to the relevant social work departments on the 14th of March 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 31st of March 2022. Two further reviews of the CAPA were required with the final deemed to be satisfactory, and the inspection service received evidence of the issues addressed. On this basis Regulation 7 was deemed met and the attached condition was removed on 26th of May 2022.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 163 without attached conditions from the 24th of October 2019 to the 24th of October 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.

Both young people in placement had up-to-date care plans on file and child in care review meetings (CICR's) were being held in line with regulatory timeframes. A good quality care plan was in place for the young person longest in residence; there was a detailed assessment of needs and a variety of actions for follow up by both the centre and allocated social worker. For the second young person the care plan needs assessment was very comprehensive, although it did lack a thorough focus on aftercare planning specifically planning for independent living skills. An aftercare needs assessment was completed but the accompanying aftercare plan was not on file. Both young people were supported to attend their CICR's and state their views. Between the centre manager and social workers there were clear arrangements for informing young people of decisions if they chose to not attend their reviews.

There was consistency in the young people having individual placement plans that required monthly reviewing and updating in line with needs of the young people. The inspectors identified that the centre's placement planning process continued to require improvement, a similar finding from the inspection of the centre in 2021. Continuing deficits included a lack of clinical input, lack of therapeutic programmes to guide staff in completing informed work with young people and there was a gap of planning in assigning staff to keyworking tasks for set goals. The goals outlined in the placement plan document were found to have been repetitive and for the young person nearing the end of their placement, their plan lacked clear focus in the development of skills for semi/ independent living. High staff turnover was also a contributing factor in staff being able engage in keywork with young people. Since being onsite the inspectors have been informed by centre management that efforts had recommenced in improving the placement planning system in conjunction with the clinical psychologist.

Keyworking that took place consisted of brief conversations being held with young people that was mostly opportunity-based. High staff turnover was a contributing

factor in staff being able effectively engage in keywork with young people. There was no formal process in place for capturing young people's input to the development and reviewing of their placement plans. It was not evident to the inspectors from their review of a sample of team meeting minutes that placement plans were discussed.

A number of external specialist support services, including mental health services, were available for one of the young people. There was evidence that they were encouraged by staff to access the services, but they chose to not engage with them. Stronger relationships and better skills on the team could have more positively impacted this. Staff in the centre had access to a national specialised clinical service. From interviews with staff and a social worker the inspectors did not get a clear understanding of the purpose of the national specialised clinical service in terms of how it could support the young person and if it was being utilised effectively. A more co-ordinated approach would be beneficial in guiding the staff team in collaboratively meeting the needs of the young person that should be identified at a CICR setting to ensure that all support services are aware of each other's purpose and roles. The clinical psychologist did not have a consistent input to the care being provided to the young people. They had not been available to support the newly appointed centre manager and new staff team in the months prior to the inspection. This did not comply with the centres policies and procedures.

There was evidence of contact with family. From the review of documentation and interviews there was evidence that there was good communication between the centre and social workers.

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

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

Actions required

- The centre manager must ensure that an aftercare plan is secured for one young person and that goals for developing independent living skills are included in their placement plan.
- The director of services must ensure the implementation of therapeutic programmes to guide staff in completing informed work with young people, that goals are set in conjunction with the young people, tasks are assigned to staff, goals are tracked and that there's a better recording of discussions relating to placement plans and keyworking at team meetings.
- To comply with policy and procedures the director of services must ensure that clinical support is consistently available to support the care being provided by staff to the young people.

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 as the appointed person in charge since August 2021, was charged with overall responsibility for the running of the centre. They were named as supportive and approachable by staff. The inspectors found that they were motivated and committed to delivering good care to the young people. From governance and management perspectives the inspectors identified that they required additional support both internally and externally. The internal management structure was not appropriate to the size and structure of the centre. As stated to inspectors there was a deficit in a deputy manager and a social care leader positions. There was no identified person to step up into the centre managers absence. The written delegation of tasks record did not include centre manager responsibilities, that would guide those staff with management responsibilities in the centre managers absence.

There were efforts by the centre manager in providing oversight and direction to the staff team that was still in a forming phase of development. Improvement

was required by the centre manager in demonstrating more robust oversight of records. A review of the centre's recording systems was required for example the format of the daily log report lacked space for the centre manager to provide feedback and/or direction. This too could be found from the keyworking templates. The quality of information recorded in the daily logs was mixed with some daily records very brief and others containing more detailed information that was reflective of a young person's day. From the review of team meeting minutes direction by the centre manager was repetitive; staff should be more accountable for signing daily logs and other paperwork specific to the young people. Team meetings were being held regularly; the template for recording discussions requires improvement and a set agenda is required. In follow up to last year's inspection there was no evidence that the protected disclosures policy was reviewed with the staff team. The staff team had been tasked with making themselves familiar with the whistle blowing and protected disclosure policy. There was no evidence to indicate that this occurred.

The centre manager reported to the director of services who visited the centre approximately fortnightly. At the leadership of the director of services the centre manager was no longer required to complete monthly managers monitoring reports or weekly reports on the young people. A social worker had asked for these to be reintroduced and this had commenced for the young person they were allocated to. The monthly monitoring report had been one mechanism the director of services utilised in completing their monthly auditing reports. They now reviewed documents during their onsite visit and those received digitally. Inspectors found that the internal auditing system was not connected to the National Standards, HIQA (2018). A single external audit that was based on a single theme had taken place since last inspection. It was stated in policy that external auditing would occur every three months.

The centre's policies and procedures were reviewed and updated in December 2021. The updated document did not include a policy and procedure on restrictive practices as required in the National Standards, 2018, or procedures for on-call to support the on-call statement. Inspectors also found in interview that staff were not aware that a policy on staff retention was in place.

The centre had a risk assessment and management policy and procedure document. It was the inspectors' findings that the centre was in its infancy stages of implementing the risk assessment framework in practice. The inspectors reviewed risk related documentation and the risk register that mostly recorded risks presented

by the individual young people. Staffing deficits was included too which is appropriate. The centre register should not be about the young people. Risk related information relating to young people should be stored in their individual care files. Individual risk assessment plans included individual crisis support plans, absence management plans and behaviour support plans. The centre manager demonstrated an understanding of the risk assessment process in operation however, failed to identify potential safeguarding and health and safety risks relating to the ongoing presenting behaviours of the young people. The strategies in place were not targeted enough to address the problematic high-risk behaviours and vulnerabilities presenting for example the recent installation on sensor system in response to a peer of one of the young people entering the centre unknown to staff was not proving effective as it reoccurred. The introduction of the 50:50 live night did not prove effective either. A level of bullying behaviour by one young person towards the other resident remained, despite work completed by staff in this regard. The separate programmes in place were not proving effective in encouraging them to keep apart to manage the intimidatory behaviour of one young person. A mix of inadequate staffing levels and a good skills base was impacting in appropriate prevention and interventions being carried out. The risk register required review as the impact scores and likelihood scores did not match.

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

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

Actions required

- The director of services must ensure that the centre has an appropriate internal management structure.
- The director of services must ensure that alternative managements arrangements are in place when the centre manager is absent.

- The centre manager must demonstrate greater oversight and leadership across records and at team meetings that is clear and specific of action required.
- The centre manager must improve the format of the the team meetings to ensure that there's a more robust recording of discussions and decisions made relating to the young people and operational running of the centre.
- The director of services must ensure themselves that internal and external auditing practices align to centre policy and procedures.
- The director of services must ensure that the centres policies and procedures fully align to the National Standards, HIQA (2018). Staff must then be provided with training on the updated policies and procedures document.
- The director of services must continue to strengthen the risk management framework to ensure it adequately identifies, assesses, and manages risks to the centre and young people.
- The director of services must ensure that centre management and staff have a greater awareness and understanding of what behaviours constitutes risk. Effective strategies to minimise risk must be identified to include developing the skill base of the staff team.

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.

At the time of the inspection the staff team consisted of a full-time centre manager, two full-time social care leaders and five full-time social care workers. As per the requirements set out in the Tusla ACIMS memo, February 2020 and article seven of the 1996 regulations the centre was operating outside of these. The staffing deficit being one full-time staff position. The daily rota required two staff completing 24.5hr sleepover shifts. As highlighted earlier in this report the skills base or experience of the staff team was not strong enough to implement targeted and informed plans with the young people. Incidents that had occurred in the centre were due to poor workforce planning for example placing a relief social care worker on shift with a newly recruited staff member.

Including the centre manager, a total of six staff were appropriately qualified with one staff qualified in a related field. Two staff members were not qualified in a suitable or related field. There was one consistent relief social care worker, who was not appropriately qualified, available to support the staff team during times of leave.

Since the last inspection in June 2021 the centre had experienced high staff turnover. A total of 11 staff across centre management and staff positions had left the centre. As detailed in the inspection information form reasons cited for leaving included a return to teaching, resignation and moves to other social care sectors. One resignation arose from separate complaints by the two young people. The complaints process was implemented and whilst it was being investigated the staff member resigned from their post. In interview the director of services spoke of their difficulties in recruiting and retaining staff. Over the totality of the current registration cycle the centre had experienced significant staff instability. Since the centre opened in 2019 there had been a complete change in centre management and staff. For the young person longest in resident no single staff member had remained in the centre since they were admitted. In interview their social worker confirmed they had not been made aware of any issue regarding this by them. They also stated that the young person had not formed an attachment to any staff member. This was impacting in a continuity of care being provided to them and the other young person in placement.

The inspectors reviewed four exit interview records. The questions included in the exit interviews form were not focused towards receiving feedback on how aspects of the organisation could be improved to retain staff, especially experienced staff.

The inspectors reviewed a sample of staff personnel files and observed several deficits including not having the required documentation and not being in line with child safeguarding guidelines and relevant legislation. Employment references, validation of the single reference on file, a copy and verification of qualification was required for one staff. For another staff a risk assessment was not on file for a garda vetting disclosure. The inspectors were provided with the information following the onsite piece of the inspection. The centre manager and director of services must complete a full audit of personnel files and obtain all outstanding documents. There were deficits in recruiting procedures and recruitment processes being adhered to for those in internal management roles. Interviews for two positions did not take place with a position offered to a staff member who did not have the relevant experience required of the role.

The centre manager and director of services held on-call responsibilities for evenings and weekends. The centre's on-call statement was not supported by procedures. The centre manager stated they were contacted by staff at evenings and during weekends regardless of on call arrangements in place. Centre management stated they are in the process of devising a rolling on call rota to include social care leaders.

Staff interviews conducted identified that staff were not aware of the staff retention policy and of initiatives in place. The director of services stated that such initiatives included an employee assistance programme and incremental pay. Stronger efforts are required by the organisation to encourage staff retention and ensure that a continuity of care is provided so young people experience stability under criteria 6.1.5 of the National Standards, HIQA (2018).

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

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

Actions required

- The director of services must ensure that the centre is operating with the staffing level requirements set out in the Tusla ACIMS memo, February 2020 and the 1996 regulations.
- The director of services must ensure that the centre is operating with the staffing qualification requirements set out in the Tusla ACIMS memo, February 2020 and the 1996 regulations.
- The director of services must ensure that regular qualified and experienced relief staff are available to support the staff team and cover the varying types of leave.
- The centre manager and director of services must complete a full audit of personnel files and obtain all outstanding documents.

- In line with policy the director of services must adhere to recruitment processes when filling positions in the centre.
- The director of services must ensure that the on-call policy is developed to include procedures and that staff have a better understanding of the support system.
- The director of services must immediately address the issue of high staff turnover to ensure young people experience staff stability and a continuity of care. Staff retention must be a priority and current initiatives to retain staff must be reviewed.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that an aftercare plan is secured for one young person and that goals for developing independent living skills are included in their placement plan.	Completed. After care plan is on file. Independent living skills are more focused within the monthly placement plan in line with the young people's understanding and capacity and in consultation with the clinical psychologist.	The centre manager will ensure that when required each young person will have an after care plan on file.
	The director of services must ensure the implementation of therapeutic programmes to guide staff in completing informed work with young people, that goals are set in conjunction with the young people, tasks are assigned to staff, goals are tracked and that there's a better recording of discussions relating to placement plans and keyworking at team meetings.	The consulting clinical psychologist is now taking responsibility for implementing and reviewing therapeutic programmes into the placement plans. Discussions at team meetings in relation to placement plans and key work will now be more robustly evidenced, and tasks assigned will be followed through.	The consulting psychologist has committed dates for implementation for the remainder of the year. The director of services attends clinical meetings and will conduct monthly auditing to ensure all keywork assigned is completed and the young people engage.
	To comply with policy and procedures the director of services must ensure that	Completed. The clinical psychologist has committed to providing monthly clinical	The clinical psychologist has committed to providing monthly clinical support to the

	clinical support is available to support the care being provided by staff to the young people.	support to the team and has provided dates for the remainder of the year.	team and has provided dates for the remainder of the year.
5	The director of services must ensure that the centre has an appropriate internal management structure. The director of services must ensure that alternative managements arrangements are in place when the centre manager is absent. The centre manager must demonstrate greater oversight and leadership across records and at team meetings. The centre manager must improve the format of the team meetings to ensure that there's a more robust recording of discussions and decisions made relating	Completed. The centre is in process of appointing a deputy manager and has appointed a social care leader. The experienced deputy manager will deputise for the centre manager. Daily logs now have a section for the manager to comment on the days' events. The centre manager has introduced a new team meeting template to better evidence discussions and decisions made. They are now completing a weekly audit of the	The director of services has committed to attending the centre daily to support the management team's development and skills. The director of services will be available to the deputy manager for guidance, advice, and support in the absence of the centre manager. They will be attending daily handovers to support the building of staff skills The director of services receives a copy of the centre manager's weekly audit every Friday via email. This will evidence the centre manager's oversight and leadership across all centre records. The director of services attends all team meetings and now receives a copy of the team meeting minutes. The centre manager now reviews team meeting

	to the young people and operational running of the centre.	centre records. Staff have received training in completing minute taking at team meetings.	minutes to ensure actions are carried out as part of the manager's weekly audit. The director of services audits team meeting meetings as part of monthly auditing.
	The director of services must ensure themselves that internal and external auditing practices align to centre policy and procedures.	Completed.	Next external audit under Theme 6 has been confirmed and these audits will take place every three months.
	The director of services must ensure that the centres policies and procedures fully align to the National Standards, HIQA (2018). Staff must then be provided with training on the updated document.	A review of all policy and procedures is underway. This will be completed by end April 2022. Staff will be provided training in the updated policy and procedures by the director of services and how all policies translate to practice.	Policies are reviewed annually or sooner if required. All policies will be reviewed every six months with the staff team for the staff to be familiar with the policies.
	The director of services must continue to strengthen the risk management framework to ensure it adequately identifies, assesses, and manages risks to the centre and the young people.	The risk management policy is under review. The risk register has been amended, a risk register for each young person and a centre risk register has now been developed.	The director of services will review risk assessments and risk registers as part of monthly auditing.
	The director of services must ensure that centre management and staff have	The director of services has committed to attend daily handovers to support the	Risk Management Policy remains under review. The director of services will be

	a great awareness and understanding of what behaviours constitutes risk. Effective strategies to minimise risk must be identified to include developing the skill base of the staff team.	developing skill base of the entire staff team for a period. Strategies in place to minimise risk will be reviewed at each hand over to ensure their effective implementation.	based in the centre for a period to support the staff team in identifying what constitutes risk and how best to manage it within the development of robust safety plans and will review risk assessments and risk register as part of monthly auditing.
6	The director of services must ensure that the centre is operating with the staffing level requirements set out in the Tusla ACIMS memo, February 2020 and the 1996 regulations. The director of services must ensure that the centre is operating with the staffing qualification requirements set out in the Tusla ACIMS memo, February 2020 and the 1996 regulations. The director of services must ensure that regular qualified and experienced relief staff are available to support the staff team and cover the varying types of leave.	Completed. A deputy manager in process of being appointed. A social care leader position has been filled. All newly appointed staff are qualified in social care and are experienced. Current staffing deficits have been filled with qualified and experienced staff in line with the Tusla ACIMS memo. Two relief positions are currently being recruited for.	Recruitment will remain on going. Staff retention policy has been reviewed and all staff are made aware of the policy. The director of services will ensure that as occupancy levels increase all new appointees will have the appropriate social care qualification or a relevant qualification. The centre is fully staffed at present. As occupancy levels increase recruitment will remain ongoing.

	The centre manager and director of services must complete a full audit of personnel files and obtain all outstanding documents.	Ongoing. Outstanding documents have been requested. The director of services will conduct a review of all newly appointed staff to ensure all relevant information is on their personnel file before commencing employment.	The director of services will now review the personnel file of any new recruit prior to them taking up the role to ensure all required documentation has been obtained and is on file.
	In line with policy the director of services must adhere to recruitment processes when filling positions in the centre.	The director of services will ensure all positions are filled following a successful interview for that position.	The director of services will ensure relevant staff availability to form interview panels in future.
	The director of services must ensure that the on-call policy is developed to include procedures and that staff have a better understanding of the support system.	Completed. The on-call policy has been reviewed to include the procedure for contacting on call.	All staff is aware of this policy.
	The director of services must immediately address the issue of high staff turnover to ensure young people experience staff stability and a continuity of care. Staff retention must be a priority and current initiatives to retain staff must be reviewed.	Ongoing. Staff retention policy will be reviewed by the end of April 2022. Staff will be notified of any changes when this review is complete. The director of services has committed to attend daily handovers in recognition of the need to build on the skill base of the team and to	The director of services is now based in the centre and attends daily handovers. This is to improve systems, structure and support the development in staff skills.

		ensure the staff team feels confident and supported with clear direction and support.	