An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 193

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Brighter Futures for Children**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced Inspection**
Date of inspection:	**21st, 23rd and 24th March**
Registration Status:	**Registered from 17th May 2021 to 17th May 2024**
Inspection Team:	**Lorna Wogan** **Paschal McMahon**
Date Report Issued:	**13th 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 on the 17th of May 2021. At the time of this inspection the centre was in its first registration and was in year one of the cycle. This was the second inspection of the centre in its first year of registration. Following the previous inspection of the centre on the 04th, 09th and 11th November 2021, the findings of the inspection were that the centre was not operating in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: *Care Practices and Operational Policies*, Article 7: *Staffing* and Article 6: *Person in Charge.*

It was the decision of the registration committee to add a condition to the centre's registration under Part VIII Article 61 (6) (a) (i) of the Child Care Act 1991. The condition being:

- 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* and Article 7: *Staffing* and that appropriate and suitable care practices and operational policies are in place and that the staffing requirements in the centre are appropriate having regard to the number of children residing in the centre and the nature of their needs.

At the time of the inspection the centre had a condition attached as set out above however the findings of the inspectors following this inspection was that sufficient work had been undertaken to address the regulatory deficits.

The centre was registered to provide multi-occupancy placements for up to two young people, male and female, aged thirteen to seventeen years on admission. The centre's stated objectives were to provide a safe and structured residential environment with a high level of support in line with *The Three Pillars Model of Care (Three Pillars of Transforming Care, Bath and Seita, 2018)*. The model was based on three key elements: safety, connections and coping. The therapeutic approach focused on emotional containment and positive reinforcement to assist young people to develop internal controls of behaviour and to promote resilience and responsibility. There was one young person 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.

Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 13th May 2022 and to the relevant social work departments on the 13th May 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 3rd June 2022. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 193 without attached conditions from the 17th of May 2021 to the 17th of May 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

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.

As with the findings of the previous inspection the inspectors found this standard was well met in relation to care planning and centre-based placement planning for the young person. There was a good standard of report writing and a record management system that evidenced the planning processes, care practices, model of care and the interventions and outcomes for the young person in placement. Interventions and outcomes for the young person were recorded and evidenced in weekly reports, daily logs, in key work schedules and in the placement plan.

There was evidence of open and honest communication with the young person in relation to the placement planning process. There was evidence that the staff supported the young person to develop an understanding of behaviour that challenges and supported them to identify alternative coping mechanisms. There was evident progress for the young person in placement and this was acknowledged in the records by both the social worker and the aftercare manager. The social worker was satisfied that the centre staff were implementing the goals of the care plan.

There was a care plan on file that was updated following the most recent child in care review in February 2022. The care planning processes were found to be in line with the requirements of the statutory regulations. The records evidenced regular communication with the social worker to ensure implementation of the identified tasks set out on the care plan. There was evidence that the centre management had systems in place to ensure that updated care plans were on file in the centre. The care plan was comprehensive and detailed the aims and objectives of the placement with input from Tusla Aftercare Services. While the young person declined the opportunity to participate in their most recent child in care review they were provided with the opportunity to have their voice heard at the meeting and were provided with feedback on the decisions taken. This was evidenced in the key working records. The inspectors found the care plan reflected the young person's views. The key workers provided written reports to the child in care review meetings.

All communications with the young person's parent were managed by the allocated social worker.

There was evidence on file that monthly planning and strategy meetings occurred outside of the statutory review process to ensure robust planning for the young person. The young person had attended the most recent of these meetings. A clear and detailed record of these meetings were maintained by the centre managers and stored on the care record.

The young person had a placement plan on file that was updated monthly since their admission. The staff interviewed were familiar with the key goals of the placement plan and how they were to be met. The placement planning process was clear and staff could explain how it worked in practice. The inspectors found that key working and individual work was linked to the placement plan, was proactive and completed to a good standard. It was also evident that staff were held accountable for the work assigned to them and that placement plans were discussed in team meetings and management meetings. Staff were progressing aspects of aftercare planning in terms of budgeting, life skills, cooking and laundry. There was evidence of progressing goals in several areas as each placement plan was updated and it was evident that the plan was a live working document for staff and managers. The key work records also reflected the young person's voice on aspects of their life. Overall, the inspectors found that the goals of the placement plan were aligned to the care plan.

The young person was facilitated and supported by staff to access specialist supports and the young person's engagement with support services was documented on file along with communications between staff and external specialists. Staff had an awareness of mental health issues and were proactive in seeking additional supports for the young person as required.

There was effective communication and good collaboration between the range of professionals involved in the young person's care and this was evidenced on the care records and confirmed by the external professionals interviewed by the inspectors. There was evidence of effective interagency and inter-disciplinary practice.

Compliance with Regulations	
Regulations met	Regulation 5
Regulations not met	None identified

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

Actions Required:

- None

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.

At the time of the inspection there was an acting manager in place. This person was due to go on a scheduled period of leave shortly after the inspection. The inspectors advised the registered provider to notify the Alternative Care Inspection and Monitoring Service of the planned changes in management when the acting centre manager departs on planned extended leave in April 2022.

The inspectors found that the acting centre manager and the deputy manager had established a strong working relationship and were effective managers. Internal management meetings were now taking place regularly with a focus on all key matters for the young person and the operation of the centre. The acting centre manager received regular supervision, support and guidance from the registered provider, and this was reflected in the comprehensive and detailed supervision records reviewed by the inspectors. The staff interviewed told the inspectors that management and leadership was effective in the centre. The acting centre manager

and the deputy manager were no longer required to work shifts to cover staff shortages and were able to attend fully to their management tasks. This had significantly improved governance management and oversight in the centre.

The internal management structure of the centre was appropriate to the size and purpose and function of the centre. There was a centre manager, deputy manager and two social care leaders. At the time of the inspection a recently recruited social care leader had left the service however a new social care leader was recruited and was due to commence employment in the coming weeks. Roles and responsibilities were discussed in the centre induction process and in supervision. There was evidence that the social care leaders were inducted into their specific role and additional responsibilities as leaders on the floor.

Inspectors found improved systems of governance and oversight across the organisation. At the time of the last inspection there were no external systems in place to audit centre practices and the inspectors found that this matter had been adequately addressed. There were arrangements in place to ensure external audits were undertaken while the quality assurance manager was on scheduled extended leave. This system was working well in practice and inspectors were provided with copies of recent audits, one based on Theme 3 of the National Standards for Children's Residential Centres, 2018 (HIQA) and an audit of staff files as required following the last inspection. The audit highlighted deficits in the staff personnel files and the managers were working to secure all the required documents on file. The inspectors found that audit findings were discussed at senior management level and issues arising in audits were shared with the staff at team meetings and action taken to address identified deficits within reasonable time frames. The registered proprietor was aware of all issues of risk in the centre and had oversight of implementation of action plans. The registered proprietor visited the centre, was accessible to staff and spent quality time with the young person in placement. There was evidence in the staff communications book of the visits undertaken by the registered proprietor.

Since the last inspection there was evidence that management meetings took place on a fortnightly basis and were well attended and documented. There was evidence of discussion around child protection, safeguarding, significant events, behaviour management, risk, workforce planning, staff development, audits, shared learning, complaints, Covid 19, and other operational issues. Team meetings were also regular and well attended. There was evidence of openness and transparency in the team and that team members and managers held each other to account. There was evidence

that staff supervision was in line with the centre policy and supervision records were of a good standard and issues arising were well analysed with focused follow up with staff.

This organisation was not currently part of a contracting arrangement with the National Private Placement Team (NPPT) and were still operating on a former placement agreement. The registered proprietor informed inspectors that they planned to apply for a new contract through the national tendering process. There was regular contact with the NPPT.

A review of the centre's policies and procedures was a required action following the previous inspection in November 2021. The inspectors found that the centre was now compliant with Regulation 5 of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 in relation to the care practices and operational policies. The policy document was recently signed off by the registered proprietor and the inspectors found there was a plan in place to circulate the new policy document to the staff team and assess their understanding of the policies through team meetings, auditing processes and staff supervision. The centre had updated their child safeguarding policy and the inspectors were provided with evidence that the centre's child safeguarding statement was deemed to be compliant with the requirements of the Children First Act 2015. The registered provider must now provide training for the staff team on their recently updated child safeguarding policy.

There was a risk framework and supporting structures in place in the centre for the identification, assessment and management of risk. There were significant improvements in how the risk management system was organised, understood and operated in practice. Staff were able to describe the system and how it supported the identification, management and review of risks. They were alert to risk and there was continued good identification of individual risks associated with the young person's behaviour. The young person had a placement support plan that was up to date and included an absence management plan and an individual crisis support plan. Inspectors found that risks associated with the centre were reviewed at all levels of management. There was one restrictive practice in place which was assessed and agreed with the allocated social worker and was subject to review.

Covid 19 was well managed in the centre. There were robust protocols in place and guidance was updated in line with public health guidance, cleaning schedules, sanitisation, and adequate provision of PPE were all in place. The centre now has

sufficient relief staff to implement a staffing contingency plan and to cover sick leave and annual leave as it arises.

The internal management structure comprised of the centre manager, deputy manager and three social care leaders, however at the time of the inspection the registered provider was in the process of recruiting a third social care leader and when appointed the centre will have the required complement of internal leaders.

There were arrangements in place for the deputy manager to manage the centre when the person in charge was absent from the centre. The centre manager and the deputy manager had developed a list of all management tasks and internal managers meeting records evidenced delegated management tasks.

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

Actions Required:

- The registered provider must notify the Alternative Care Inspection and Monitoring Service of the planned changes in management when the acting centre manager takes planned extended leave in April 2022.
- The registered provider must provide training for the staff team on their recently updated child safeguarding policy.

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.

Since the last inspection in November 2021 there was a significant focus on staff recruitment. There was evidence that the registered provider had recruited the required numbers of staff to ensure the centre had sufficient staffing in line with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7: *Staffing* and with the Alternative Care Inspection and Monitoring memo on staffing numbers and qualifications (February 2020). However, due to the departure of one of the recently recruited social care leader the centre was operating with 7 social care staff on the core team. The centre had recruited a new social care leader who had accepted the post and was due to commence work in the centre in April 2022. When this person is in post the centre will have achieved sufficient staffing numbers in line with the requirements until then the regulation on staffing is not met. The current team comprised of acting centre manager, the deputy manager, two social care leaders with one on boarding and five social care workers. At the time of the inspection the centre had achieved the staffing requirement to have 50% of the team with a recognised social care qualification.

There was inadequate relief staff available to cover sick leave and annual leave at the time of last inspection. The inspectors found that new relief staff were recruited and there were now five relief staff available to cover all types of planned or unplanned leave as it arose. There were two relief staff that were regularly used to provide cover and they were familiar to the young person. The rosters were reviewed from November 2021 to March 2022 and the inspectors found that there were always two staff on duty to support the young person in line with their contracting requirements.

There was good evidence of staff being supported in their work and care practices monitored by the managers. Workforce planning was a central aspect of staff supervision and evidenced in the staff supervision records. In general, the current supervision process demonstrated robust leadership, accountability, a focus on self-care and professional development, feedback on work and commitment to the service.

There was evidence that workforce planning was now built into the strategic development process for the organisation. The records of the senior management meetings, the internal management meetings and team meetings evidenced that staff recruitment and retention of staff were central to the discussions. The HR business manager who was appointed at the time of the last inspection was no longer working in the organisation however the recruitment process had not been impacted by this.

The inspectors found that the team had stabilised and the inspectors observed a positive team dynamic when on site. It was a newly established team with two new social care leaders, a third one on boarding and three new social care staff so the team were in the forming stages of development at the time of the inspection. However, the inspectors found that the centre managers had developed staff cohesiveness in a short period of time and there was evidence that the new social care leaders had become well established in their leadership role. The rosters reviewed evidenced that staff were not required to work double shifts as was required of staff on the last inspection. The requirement for staff to do overtime has been eliminated and staff are now able to plan to take annual leave.

There was evidence that the centre managers had audited the staff personnel files following the last inspection to ensure all the required documentation is maintained on each personnel file. A review of a sample of personnel files by inspectors showed some additional gaps and deficits that needed to be addressed. There were vetting disclosures in relation to staff members and the risk assessments in relation to these disclosures were not on file at the time of the inspection. The inspectors were subsequently provided with the written risk assessment report in relation to one vetting disclosure, however the inspectors determined this was not sufficiently robust. A second risk assessment was outstanding. The registered provider must ensure that written evidence of risk assessments undertaken following vetting disclosures is maintained on staff personnel files along with the police vetting documentation.

Verbal references were completed on references however some verbal reference checks were not signed by the person who undertook the verbal reference check and had no commentary in relation to the verification of the information on the written reference. The registered provider must ensure that the verbal reference checks are signed and there is a record confirming that the information on the written reference is accurate.

Following a review of staff personnel files, the inspectors found there were unsafe recruitment practices in place. Inspectors found that the registered provider did not always secure references from the most recent employer. Further, it was found that some curricula vitae were lacking in detail and that the verification of qualifications was not sufficient.

Additionally, it was noted by inspectors that one staff member was recruited and commenced employment in August 2021 two days prior to receipt of Garda vetting. This is in breach of the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 -2016.

There was now a system in place to conduct and evaluate exit interviews to inform service improvements and feed into staff retention. There were two exit interviews undertaken with staff, one with a staff member who moved to relief work and another with a staff member who had planned to move from the service at the time of the last inspection. The exit interviews reviewed provided opportunities for staff to comment on positive experiences and areas that required improvement. The registered provider must track issues raised in exit interviews and use this information to inform service improvements. Staff interviewed identified measures in place to retain staff such as quality supervision, an employment assistance programme, support from external consultants, pension contributions, pay scales, training and strong leadership and management.

There was a system in place to record and track staff training. Staff had completed the appropriate first aid training in February 2022 and all staff members had behaviour management training and refresher training was up to date. All staff had completed Children First training. Several new staff members required fire safety training and the registered provider stated that fire safety training, on site, was being planned for staff at the time of the inspection.

There was an effective on-call system in place to support staff after office hours and at weekends/holidays. On call was provided on a rotational basis between the centre managers, deputy managers and social care leaders. Staff were clear of thresholds for contacting the on-call manager.

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

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

Actions Required:

- The registered provider must ensure that written evidence of risk assessments undertaken following vetting disclosures are maintained on staff personnel files along with the police vetting documentation.
- The registered provider must ensure that the verbal reference checks are signed by the person completing the check and there is confirmation that the information on the written references is accurate.
- The registered provider must ensure that their vetting and recruitment practices are robust and in compliance with the statutory requirements for vetting and recruitment.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	N/A		
5	The registered provider must notify the Alternative Care Inspection and Monitoring Service of the planned changes in management when the acting centre manager takes planned extended leave in April 2022. The registered provider must provide training for the staff team on their recently updated child safeguarding policy.	The registered provider has advised the Alternative Care Inspection and Monitoring Service on 13th April 2022, that they will manage the centre in the interim until a new manager is appointed. All staff received training on the Child Safeguarding Policy during a team meeting on Tuesday 12th April. Two staff members produced a PowerPoint presentation, which was discussed.	The registered provider will advise the Alternative Care Inspection & Monitoring Service of the new managers appointment when they commence their employment. Policies are discussed during the regular fortnightly team meetings. Child Safeguarding policies will be included in the discussions on an ongoing basis.
6	The registered provider must ensure that written evidence of risk assessments undertaken following vetting disclosures are maintained on staff personnel files along with the	The registered provider has drawn up a protocol on 30th May 2022, for the management of the risk assessments of applicants when vetting disclosures indicate the need for an assessment of risk.	Staff have been advised to contact the Quality Assurance & Governance Manager when a vetting disclosure indicates the need for an assessment of risk. The House Managers will conduct the risk assessment

	police vetting documentation.	All assessments will be written up and maintained within the staff personnel files.	in conjunction with the Quality Assurance & Governance manager to ensure compliance with the protocol.
	The registered provider must ensure that the verbal reference checks are signed by the person completing the check and there is confirmation that the information on the written references is accurate.	The registered provider has instructed managers, (3rd June 2022) to ensure all reference forms are signed after verifying references and confirming with the referrer that the contained information is accurate.	The Quality Assurance & Governance Manager will review all reference forms prior to the applicant commences employment to ensure reference form are completed properly and suitable for the purpose.
	The registered provider must ensure that their vetting and recruitment practices are robust and in compliance with the statutory requirements for vetting and recruitment.	The registered provider has produced a checklist for managers (3rd June 2022) to outline the written evidence required during each stage of the recruitment process. This checklist will ensure no applicant is employed until all required information has been obtained in the correct manner and stored in the applicant's personnel file.	The Quality Assurance & Governance Manager will inspect personnel files as part of the audit process and report on compliance with the checklist.