An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 209

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Solis GMC**
Registered Capacity:	**Six young People**
Type of Inspection:	**Announced**
Date of inspection:	**19th, 20th & 21st June 2023**
Registration Status:	**Registered from 27th September 2022 to 27th September 2025**
Inspection Team:	**Lorna Wogan** **Janice Ryan**
Date Report Issued:	**23rd August 2023**

Contents

1. Information about the inspection **4**

1.1 Centre Description
1.2 Methodology

2. Findings with regard to registration matters **7**

3. Inspection Findings **8**

3.1 Theme 3: Safe Care and Support (Standard 3.1 only)
3.2 Theme 5: Leadership, Governance and Management (Standard 5.2 only)
3.3 Theme 6: Responsive Workforce (Standard 6.3 only)

4. Corrective and Preventative Actions **18**

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 27th September 2022. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from the 27th September 2022 to the 27th September 2025.

The centre was registered as a multi-occupancy, transition centre and provided six apartments in semi-independent living arrangements for young people aged 16.5 to 17 years on admission. There were no young people living in the centre at the time of the inspection. The service aimed to provide a tailored level of support to each young person characterized by an orientation toward self-supported accommodation in their indigenous community or a community of their choice. Referrals were processed through Tusla's National Private Placement Team.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2
6. Responsive Workforce	6.3

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

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 21st July 2023. 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 02nd August 2023. 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: 209 without attached conditions from the 27th September 2022 to the 27th September 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

The inspectors found that the centre operated in line with and complied with the relevant procedures as outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017 (DCYA) and the Children First Act, 2015. The inspectors reviewed a care file of one young person who was recently discharged from the centre. The file evidenced that concerns about the welfare and protection of that young person were appropriately identified and reported in line with Children First. Additionally, staff were alert to concerns in relation to child sexual exploitation and responded appropriately following the correct Tusla reporting protocols. Staff interviewed by the inspectors identified a number of child safeguarding policies that promoted safe care such as anti-bullying, lone working and complaints.

The centre had developed its own child protection policies and procedures to protect young people from all forms of abuse and neglect. The inspectors found that the policy was not fully up to date in line with the requirements under Children First - National Guidance for the Protection and Welfare of Children, DCYA 2017. The inspectors recommend the director undertakes a further review of the policy to ensure it is fully aligned to Children First.

There was evidence that staff had received internal training on Child Protection and Child Safeguarding at both their centre induction and more recently during a full week of refresher training when there were no young people in placement. There was evidence on the personnel files and staff training records that staff had completed training in all three Tusla Children First e-learning modules, Children First Mandated Person's training and Tusla Child Sexual Exploitation training (CSE). There was one staff member yet to complete CSE training and this was identified by the inspectors in the course of the inspection. Staff and managers interviewed displayed a good understanding of the management and reporting procedures in place where there were concerns about a young person's welfare and protection. Staff interviewed were aware of their roles as mandated persons under the Children First

Act, 2015 and each staff member had access to the Tusla Portal and were trained to complete and input a mandated report. A list of all mandated persons was displayed in the centre as required under the legislation.

The centre had developed a Child Safeguarding Statement as required and provided evidence of a letter of compliance from Tusla's Child Safeguarding Statement Compliance Unit (CSSCU). Staff interviewed were aware of the statement and where it was displayed in the centre. The inspectors recommend that the Child Safeguarding Statement is reviewed periodically at team meetings to ensure staff are fully familiar with the risk of harm/abuse young people may be exposed to while living in the centre and the policies, procedures and practices in the centre identified to mitigate these known or potential risks. The inspectors sampled five personnel files and found that they contained satisfactory Garda vetting for staff prior to their commencement of employment.

The inspectors found that the identification of harm and risk of abuse had significantly improved since the previous inspection in December 2022. However, the inspectors identified that improvements were required in the internal recording and administrative practices in relation to reported concerns. Following a review of two concerns reported to Tusla, in one instance, the documentation did not have a corresponding significant event notification form (SEN) on file and for the second concern the SEN was on file but the child protection and welfare reporting form (CPWRF) was not stored on file. Records of communication to social workers in relation to the status of the reported concerns should also be filed together with the CPWRFs for tracking purposes and to evidence outcome of the reported concern. Additionally, tracking numbers were not shown on the relevant documents or on the centre's child protection register to help with tracking the reported concerns. The centre manager must review all child welfare and child protection documentation to ensure that all relevant documentation relating to the concern is stored in the one location on the individual care records.

The inspectors found that the managers and teams' response to risk taking behaviours had improved since the last inspection in December 2022. There was evidence of multi-disciplinary meetings taking place, safety plans developed, regular reviews of the safety plans following incident and evidence of strengthened oversight of this by managers and social workers. There was evidence of regular communication with social workers and strategy meetings were scheduled in response to escalation of risk or emerging high-risk concerns. Welfare checks as set out in the safety plans were shown in the daily logs. Actions in response to risks were set out in the absence management plans (AMPs), the individual crisis support plans

(ICSPs), the personal support plans (PSPs) and on the individual risk assessments. On admission the manager clarified with the social worker how parents were to be informed of any incident or allegation of abuse.

Following a review of safety plans the inspectors recommend that safety plans are developed for specific individual concerns/incidents that require added staff attention or more inputs and safeguards outside of the safety measures set out in AMPs, ICSPs, PSPs and individual risk assessments. In one instance the inspectors found that a social worker requested a room search be carried out following additional concerns relating to a young person. The centre staff were concerned to undertake the search as requested as this was not in line with their policy. The inspectors recommend that the centre policy on room searches is reviewed in relation to the safety and welfare of the young people which must supersede their right to privacy in cases where there are substantial concerns about risk. An agreed protocol for room searches must be outlined on admission to both the social worker and the young person and incorporated into the risk management documentation. The centre policy on room searches must be updated and reviewed in this regard.

Inspectors found that individual work was undertaken with young people to develop the skills needed for self-care and protection. This work was completed in a sensitive and supportive manner with staff supporting young people to speak out if feeling unsafe or vulnerable. There was evidence that staff worked in partnership with parents where they were involved in their child's life and with social workers and Guardians to promote the safety and wellbeing of the young people. There was evidence that the young person who was recently discharged had formed a relationship of trust with key staff and felt comfortable to talk to them around more sensitive topics relating to their safety, welfare and wellbeing.

The centre had a policy on protected disclosures. Staff interviewed were familiar with the protected disclosure policy and their right to raise concerns about the service with external bodies such as Tusla, Ombudsman's Office or the Health Information Quality Authority. The supervision records evidenced discussions with staff reassuring them of the importance to speak out if concerned about any aspect of the service. However, in staff interviews there was confusion about who staff would contact internally if a concern arose about the Providers who were all related through family connections. Following the inspection, the director issued a new memo for each staff member that provided clarity for staff as to the named person external to the Provider. The director confirmed this memo will be signed by each individual staff member and placed on their supervision file.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
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 3.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The service director and the centre managers must undertake a review of their child protection policy to ensure it is fully aligned to the Children First National Guidance and the requirements of the Children First Act, 2015.
- The centre manager must ensure the child safeguarding statement is reviewed periodically at team meetings.
- The centre manager must review all child welfare and child protection documentation to ensure all relevant documentation relating to specific concerns are stored in the one location on the individual care records.
- The centre managers and service director must review the centre policy on room searches in relation to the young people's rights to privacy against the risk of harm.

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 appointed person in charge at the point of registration had resigned from their post in February 2023. In the interim, while setting up the recruitment process for a

newly appointed person in charge, the deputy manager undertook management responsibility for the centre initially and more recently one of the social care leaders was appointed as the acting person in charge until the post was filled. The inspectors found there were deficits within the internal management structure since earlier in the year in line with the staffing set out in the centre's statement of purpose, with no social care leaders in post at the time of the inspection. However, admissions to the centre were paused for a period of weeks and the director confirmed that social care leaders were identified through an internal recruitment process and were due to be appointed shortly.

Overall, despite the deficits within the internal management structure, the inspectors found the acting and interim centre managers had provided strong leadership and the governance and management of the centre had improved considerably since last inspection December 2022. This was acknowledged and recognised by the staff who met with the inspectors at the centre and who were interviewed as part of the inspection process. The director had a number of measures in place to support the service since the resignation of the person in charge such as visits by senior managers within the service, an interim auditor and regular visits by the director to the centre and their attendance at team meetings.

A recently updated organisational chart was provided to the inspectors and the recent appointment of a service coordinator/quality assurance officer was incorporated into the new governance structure. The service director had scheduled a meeting with the service coordinator/quality assurance officer to set out a compliance auditing schedule for the centre for the year ahead. The service director confirmed they will have line management responsibility for the service coordinator/quality assurance officer and have oversight of all work undertaken by them.

The governance file evidenced all the systems in place at various levels within the service to address leadership, governance and management matters. Operational management meetings were undertaken on a monthly basis. Local management meetings where the centre managers and the service director attended commenced in April 2023 with a governance and oversight agenda. Additionally, a monthly governance report was completed by the person in charge and this report contained a wide range of centre activities and data relating to the previous month. These governance reports were submitted to the service director for their oversight. There was evidence that team meetings were scheduled more consistently in line with centre policy since the last inspection. A recently changed format for recording team meetings ensured a more responsive meeting to current issues and better evidence of

issues discussed and decision taken. The centre manager must ensure that if decisions/actions are taken following a discussion these must be recorded on the meeting records. Team meeting minutes reviewed for the latter part of 2022 and early 2023 evidenced inaccuracies, some cut and paste of information and repeated issues for action from meeting to meeting. Going forward the centre manager must ensure that team meeting records are reviewed and signed off as an accurate record of the meeting. There was evidence that managers and staff members had access to the previous inspection report and were familiar with findings. There was evidence across the centre records that the service director and the centre managers had worked on the inspection recommendations and all actions required were met at the time of this inspection.

The inspectors were satisfied that the internal managers worked well together. Staff reported they were happy with the leadership in centre. Staff stated they had confidence in their managers. The internal managers attended the daily morning handover meetings Monday to Friday and were present to guide staff and have oversight of practice at the start of each day. Managers were reported to be accessible and responsive to the team's needs and responded to these needs in a sensitive and open manner. Equally, there was evidence of addressing team issues that arose through supplementary supervision where required and holding staff to account for their practice and performance. Team morale had been an on-going issue as outlined in the team meeting records earlier in the year but had evidently improved.

There was evidence of a good flow of information and updates to staff by the service director. The director visited the centre regularly and met with staff on duty. The service director attended team meetings regularly and was committed to attending team meetings on a monthly basis. Two compliance/quality assurance audits were undertaken since the last inspection. The inspectors found that these audits did not have corresponding actions plans developed to address the findings and track them to conclusion.

The centre was contracted by Tusla's National Private Placement Team. The was evidence that to date the centre faced significant challenges to meet its purpose and function. The service director had completed a detailed analysis of first six months of operations, the referrals, discharges and the identified challenges faced by service and current pressing issues. This document informed recent communications with Tusla's National Private Placement Team and with managers of Tusla's Alternative Care Inspection and Monitoring Service. There was evidence of open communication with Tusla managers to ensure the best use of the resource going forward.

The centre policy and procedure documents were reviewed and updated in March 2023. Policy and procedure training was completed at induction and was evidenced on the training records reviewed by the inspectors and policies were refreshed recently with a week of ring-fenced training for the staff team. At the time of the inspection the acting person in charge had commenced a process to review specific centre policies at team meetings. The inspectors found there were procedures in place to inform staff where policies or procedures were updated or new policies developed.

There was a risk management framework in place and supporting structures in place for the identification, assessment and management of risk. Staff had recently participated in risk management training and had practical training to complete the risk matrix in line with the framework. The acting person in charge informed the inspectors they will continue to develop the skills set within the team in relation to risk management following this training. Staff and managers interviewed were confident the service director was aware of all risks pertaining to the centre. There was evidence of the service director's guidance and direction following a review of a specific incident. The inspectors found that preadmission risk assessments were completed by social workers and signed by the person in charge and the service director. Records of admission meetings evidenced a good focus on all known and potential risks associated with the young people. Impact risk assessments and individual risk assessments were evidence on the care file. The centre maintained a risk register that was recently updated. One of the risks identified related to another centre within the company therefore needs to be removed from this register. The corporate risk register included risks relating to staff recruitment and retention and reputational damage and centre profile in community due to high-risk behaviours displayed by young people. Control measures were identified on both the centre risk register and the corporate risk register to mitigate the risks identified.

The inspectors found evidence that all management tasks were comprehensively set out and formally delegated when the person in charge was absent and then subsequently resigned from their post. A detailed record of all management tasks was set out within the centre governance folder that clearly outlined who was responsible for what and when, including the management task to ensure the happiness of the team, self-care and team bonding. There was evidence of a recent team bonding day for staff and staff informed the inspectors this was beneficial to them and they valued the opportunity provided to them by the service director. The staff stated that the service director was accessible to them when the person in charge

was on leave and this was and this support was outlined by the director at a team meeting.

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 centre manager must ensure that team meeting records are reviewed and signed off as an accurate record of the meeting.
- The service director must ensure that all quality assurance/compliance reports have actions plans developed to address the findings and track them to conclusion.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

Overall, the inspectors found this standard was met in relation to the support and supervision of staff. The inspectors reviewed six staff supervision files along with the supervision records of the acting person in charge and the deputy person in charge. The managers were supervised by the service director and the staff were supervised by the deputy manager as the acting person in charge was not trained to deliver supervision. The deputy manager was trained in supervision practice and was appropriately experienced to supervise staff. There were some gaps in the deputy's

own supervision from the time the previous manager was in post but this had been rectified at the time of the inspection. All staff had a signed supervision contract on file and supervision records were signed by the supervisor and the supervisee. Apart from the deputy person in charge the six staff supervision records reviewed by the inspectors evidenced that staff received monthly supervision in line with policy.

The staff supervision records evidenced that staff were taken through their job description and their roles and responsibilities, and they had signed a statement to verify this. The supervision records evidence that staff received feedback on their performance and tasks/goals were identified within the supervision process. Staff were provided with the opportunity in supervision to reflect on the team dynamics. Issues raised by staff were responded to in a solution focused manner and there were opportunities for staff to raise any issues or concerns. One staff member who recently resigned from their post provided positive feedback on their experience working in the centre in their resignation letter on file. Records of exit interviews evidenced positive feedback about staff experience working in the centre. Staff interviewed confirmed that probation review dates had been scheduled and the centre records evidenced that for relevant staff probation reviews had been undertaken. Annual appraisals were not due for staff members at the time of the inspection however there was a policy in place in relation to undertaking annual staff appraisals.

There were supports in place for staff following critical incidents. Staff were informed about debriefing process in their initial supervision. The deputy person in charge acknowledged the stressful nature of work at a team meeting and outlined the supports available to staff. Staff interviewed confirmed they were debriefed by a suitably trained/experienced external manager following a critical incident. There was a practice of undertaking a shift analysis which supported reflective practice. A service psychologist was available for number of independent sessions if required by staff. This was relayed to staff on a number of the supervision records reviewed. A team building day provided by the service director afforded staff to have quality time together away from work environment.

Staff interviewed were aware of the reporting lines and management structure internally and externally. While the new team members interviewed stated they were mindful to check out decisions they made with managers they equally stated they equally felt their managers would support them to exercise their professional judgement. The manager displayed good insight into the importance of reflecting on practice and learning from everyone's unique skills set and work experiences. There

was a culture of learning in the service from operational management level down to team meeting level, learning from training, learning from managers, learning from other services, learning from incidents, learning from audits and learning from inspections. It was evident from the centre records that there was a real focus to ensure there was good communication at team level and the importance that full information is passed on at handovers where deficits in communication had been previously identified. There was evidence of feedback to team by the service director following the discharge of the last two residents and the work and commitment of staff was acknowledged and this had a positive impact on staff morale.

While all the mandatory training for staff was completed the centre managers and the service director needs to undertake a training needs analysis to identify additional training in areas relevant to the specific nature of the service and develop an annual training plan.

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	**Standard 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager in conjunction with the service director must undertake a training needs analysis and develop an annual staff training plan.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The service director and the centre managers must undertake a review of their child protection policy to ensure it is fully aligned to the Children First National Guidance and the requirements of the Children First Act, 2015.	The Child Protection Policy has been reviewed and updated by service director and centre manager to ensure it is fully aligned to the Children First National Guidance 2017 and the requirements of the Children First Act 2015 completed on 23.06.23.	The Child Protection Policy will be reviewed annually by service director and centre manager. All staff will be notified of updates/amendments. Any updates or amendments will be incorporated into any future training.
	The centre manager must ensure the child safeguarding statement is reviewed periodically at team meetings.	Review of child safeguarding statement has now been added to the team meeting agenda completed 27.06.23.	Review of child safeguarding statement is now included in all team meetings. Child safeguarding statement will be displayed prominently in the centre.
	The centre manager must review all child welfare and child protection documentation to ensure all relevant documentation relating to specific concerns are stored in the one location on the individual care records.	All current child welfare and protection documentation have been reviewed by centre manager, all documentation is relevant and stored in one designated location within the care records folder, completed on 23.06.23.	The centre manager will review all future child welfare and protection documentation. Child protection and welfare report forms will be discussed at all team meetings, to ensure regular updates and resolutions are sought and stored

	The centre managers and service director must review the centre policy on room searches in relation to the young people's rights to privacy against the risk of harm.	The centre manager and service director have reviewed apartment search policy with focus of balancing the young people's rights versus risk of harm, completed on 28.06.23.	appropriately. All staff have been notified of the updated policy, this was discussed at team meeting on 05.07.23 with minutes signed off by staff. Any future updates or amendments will be incorporated into future training. The apartment search policy will also be incorporated into admission meeting agenda for future residents.
5	The centre manager must ensure that team meeting records are reviewed and signed off as an accurate record of the meeting. The service director must ensure that all quality assurance/compliance reports have actions plans developed to address the findings and track them to conclusion.	All team meeting records have been reviewed and signed off as accurate record of the meeting by centre manager and deputy manager on 24.06.23. The service director, co-ordinator and centre manager have created an action plan template immediately to be used for future audits to ensure clear action points, action plan and progress can be evidenced effectively, completed 28.06.23.	Future team meeting records will be recorded by centre manager or deputy manager to ensure consistency of team meeting records. The Service Co-Ordinator, compliance officer and service director will ensure there is clear action points identified and action plan agreed with centre manager for all future audits. Completion timescales/dates will be implemented as part of action plan and service co-ordinator/ service director will review evidence of completion once timescale has lapsed.

6	The centre manager in conjunction with the service director must undertake a training needs analysis and develop an annual staff training plan.	The centre manager is now using training needs analysis template to populate training for each staff member immediately and identify any gaps in training needed. Annual staff training plan will be updated accordingly to reflect upcoming training, completed on 28.06.23.	Training needs analysis will be reviewed monthly and kept up to date. Training needs will be included in monthly supervision agenda for every staff member. Annual Staff Training plan will be discussed at regular intervals at regional managers meetings to ensure training is shared across the organisation.