An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 222

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Two young people**
Type of Inspection:	**1st, 8th & 22nd August 2024**
Date of inspection:	**Announced**
Registration Status:	**Registered from 01st June 2023 to the 01st June 2026**
Inspection Team:	**Joanne Cogley** **Paschal McMahon**
Date Report Issued:	**22nd October 2024**

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 01st June 2023. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from 01st June 2023 to the 01st June 2026.

The centre was registered to accommodate two young people between the ages of 0 years to seventeen years. The centre was established under a pilot project commissioned by Tusla's Children's Residential Services National Placement for young people who present with complex/difficult needs and behaviours. The proposed length of placement is six months during which time Tusla will focus on transitioning each young person onwards to more sustainable and suitable placements. The centre's model of care was based on a systemic therapeutic engagement model (STEM) and provided a framework for positive interventions. STEM draws on a number of complementary philosophies and approaches including circle of courage, response ability pathways, therapeutic crisis intervention and daily life events. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.4
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 17th September 2024. 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 11th October 2024. 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: 222 without attached conditions from the 01st June 2023 to 01st June 2026 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 wellbeing and personal development.

As aforementioned the centre was established under a pilot project and the proposed length of placement was for a duration of six months. At the time of inspection both young people had been in placement a year, with extensions being approved on a three-monthly basis. This caused difficulty in long term planning for the young people and one young person had made a complaint through Tusla Tell Us Complaints procedure and the advocacy group EPIC in relation to the lack of planning around their placement. They informed inspectors they were yet to receive a response from the social work department in relation to same and had not felt listened to by the social work department. Unfortunately, inspectors were unable to make contact with this social work department, despite attempts, to clarify the response that was provided to the young person. The young person noted they were very happy living in the centre and would like the centre to remain their long-term placement. Inspectors observed interactions between care staff and young people and found them to be warm, caring and respectful. The centre manager informed inspectors it was the organisations intention to apply through the new tendering process in October 2024 for the centre to be registered as a dual occupancy centre for long term placements. Inspectors spoke with the team leader allocated to one young person and they expressed satisfaction with the placement and hoped the young person could remain long term.

Both young people had up to date care plans on file which highlighted that they required long term 'general' residential placements which was at odds with the purpose and function of the centre and the pre-admission process. Despite this the centre was attempting to adequately plan for the young people in the absence of clarity on follow on placements. The young people had placement plans on file which were reviewed monthly and focused on the young people's short term current needs. Clear individual and realistic goals were outlined in the placement plans and young people had been consulted in relation to their input into the plans.

A number of external supports were in place for both young people ranging from occupational therapy, speech and language therapy, outreach programmes and at the time of inspection respite services were being explored for one young person. Young people were engaging in services and where they refused individual work was completed around the importance of attending.

Inspectors reviewed a sample of individual work records and found these difficult to navigate as they were not maintained in chronological order. Inspectors recommend a review of the key working filing system to allow for tracking and learning purposes. Individual work reviewed was limited and opportunity lead. There was little evidence of key working being carried out in line with the goals of the placement plan instead it focused on opportunistic individual work that was led by the young people. Given the purpose of the centre this was deemed acceptable at the time of review.

Inspectors found from review of email correspondence and through interviews that there was effective communication between the centre and social work departments however one allocated social worker had not visited the centre since January 2024 which was outside of the required statutory timeframe. Inspectors spoke with one allocated team leader who stated they had regular communication with the centre manager and were kept updated on all relevant events. They also noted the regional manager was accessible if required and attended meetings relevant to the young persons placement. Despite a number of attempts by inspectors, contact could not be made with the second allocated social worker or the team leader thus the issues of statutory visits and the aforementioned young persons complaint could not be addressed.

Compliance with Regulation	
Regulations met	**Regulation 5** **Regulation 17**
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 under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- No action required.

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

Theme 5: Leadership, Governance and Management

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

The organisation had a number of mechanisms in place to assess the quality, safety and continuity of care provided to the young people. This included monthly governance reports, management meetings, team meetings, significant event review groups and audits.

It was a recommendation in the previous inspection (November 2023) that there must be an effective significant event review group process (SERG) in place. Inspectors did not find that appropriate action had been taken since then to strengthen the process and make it more robust. The current process involved all managers within the region meeting to review one significant event notification (SEN) from one centre on a monthly basis. This included a full review of the significant event notification, the individual crisis support plan and associated risk assessments. Despite the high level of incidents within the centre, only two SENs had been reviewed in this forum over a seven-month period in 2024. A review of SERG minutes showed that the managers from the other centres offered their feedback as to how the incident was managed however the minutes did not show that there was any learning discussed nor changes to practice made. The regional manager informed inspectors that in addition to this forum the centre manager could choose a SEN for discussion each month if they felt the need but it would not be fully reviewed as outlined above. Inspectors did not note meaningful recorded discussion of any other SENS through the minutes.

A separate document titled "Centre management significant event review group" was also in place, however upon review this did not constitute a SERG and instead was an audit completed by the deputy manager on a monthly basis. This was a quantitative document listing dates, times of incident, staff on shift, triggers, behaviours, consequences, external factors and patterns identified. Inspectors found that the

patterns identified section was not being utilised to explore themes or trends and instead named the type of incident eg: assault / property damage, with no further analysis provided. Utilised correctly this had the potential to be a comprehensive document for monitoring and analysing trends and a tool for shared learning. Inspectors interviewed social care workers who could not provide an overview of any SEN reviews they had been involved in, nor were they able to communicate any learnings that may have been shared following SERG meetings.

A number of child protection concerns had been reported appropriately at the time of inspection and identified risks were being actioned and monitored. Three staff members were interviewed during the course of inspection but not all had an understanding of their role as mandated persons, could identity the designated liaison person (DLP) or had login details to access the Tusla reporting portal for reporting child protection concerns. The centre manager should ensure that these concerns are addressed without delay. Whilst there was a system in place for recording of child protection and welfare reporting forms (CPWRFS), there did not appear to be any system in place presented to inspectors that allowed for tracking and analysing trends or patterns. A child protection audit had been completed by the regional manager in May 2024 and a number of deficits were identified for action. One staff member was interviewed as part of this audit and their lack of knowledge in certain areas addressed and actioned. It was noted that all actions were completed on the 5th July 2024.

A complaint audit was completed by the regional manager in November 2023 however there was no date recorded of when the audit was carried out, no action plan and the staff member interviewed as part of the audit was the centre manager thus not providing insight into social care workers understanding of the policy. Those interviewed during inspection struggled to communicate the complaint policy effectively. The complaint records reviewed on file did not contain a date of complaint therefore inspectors could not determine if they were resolved in a timely manner. In one instance a young person had made a complaint relating to their social worker, this was subsequently sent to the same social worker along with the team leader for investigation. Inspectors noted in another instance a young person complained they were unhappy with room searches being carried out. While a clear response was provided to them, they indicated they were unhappy with the response however no further action or follow up appeared to have been taken. These deficits were not identified in the November 2023 audit, it was unclear if the complaints pre or post dated the audit.

Inspectors received a proposed schedule of auditing for 2024 that was to be carried out by the regional manager through their visits to the centre. Areas to be covered in 2024 were; complaints, risk and behaviour management, child protection and supervision. The centre manager was responsible for carrying out audits on medication, training and personnel files. The schedule was not aligned to the themes of the National Standards, and whilst the recorded audits identified how they linked with the themes eg: "Supervision Audit – Theme 6" / "medication audit – Theme 4" the audit was not a full and robust audit of all the standards under the themes aligned to the National Standards. The quality assurance (QA) department also had a schedule for the year, this included analysis of exit interviews and analysis of the above-mentioned audits. From speaking with members of management during the inspection, it was evident that the QA department analysed the audits through the information provided to them in the recorded audits by management as opposed to attending the centre and reviewing files thus accepting reports sent to them as a full and accurate overview of the centre.

An annual review of compliance was completed in October 2023 prior to the last inspection. This examined compliance with the eight themes of the national standards. While this review examined compliance it was found none of the deficits highlighted in inspection was captured in the annual review of compliance.

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 5.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must review the current significant event review group process and develop an effective and robust system for reviewing significant events within this centre ensuring that staff are clear on learnings identified and changes to practice required.

- The registered provider must ensure that the annual review of compliance is robust in its nature to promote improvements in work practice and to achieve better outcomes for the young people.

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.

Inspectors spoke with members of the management team and staff team during inspection and for the most part they were clear on their roles and responsibilities. There were clear lines of reporting and responsibility. Staff also spoke of the support and guidance afforded to them by the centre manager.

There were procedures in place to protect staff and minimise the risk to their safety however inspectors noted deficits in these procedures. The organisation utilised a recognised model of behaviour management for the staff to adequately support the young people when in crisis which also served to minimise risk to all. Inspectors noted in an audit completed at the end of June 2024 seven of the ten staff did not have the required mandatory training. At the time of inspection training had occurred however two staff members remained untrained in the model of behaviour management. This delay in training was also a deficit noted in the last inspection in November 2023. The centre also had a policy in relation to driving for work. Inspectors found from a review of records that at least three staff members were spoken to by centre manager in relation to driving at excessive speeds in May 2024. Staff members travelling with other staff and young people did not observe the legal speed limits thus putting both the staff members and young people's lives at risk. Other than supplementary supervision taking place with the staff concerned there was no evidence that further action was taken by the organisation in response to these serious safety concerns.

Team meetings occurred on a fortnightly basis in the centre. The level of attendance was good and staff interviewed spoke of them being a good forum for practice discussion and learning. Inspectors reviewed a sample of team meeting minutes and found the template in use effective. Whilst some areas had detailed minutes, other

important areas lacked in recorded detail and did not allow the reader insight into discussions, particularly in the areas of significant event reviews, risk assessment review and complaints. Should a staff member have not attended a meeting, it would be difficult for them to ascertain discussions and outcomes from reviewing the minutes and this should be reviewed by the centre manager and regional manager.

One inspector attended handover on the day of inspection. Handover was conducted in a format that consisted of oncoming staff members reading daily logs from the previous day and then asking questions if required and making a plan for the day ahead. Inspectors did not witness robust communication during the handover attended with the centre manager input being minimal. The regional manager and centre manager should review the current handover format to ensure it meets the needs of planning for the young people in a robust manner.

The centre manager and deputy manager had been trained in a recognised model of supervision training and the organisation had a supervision policy in place. Staff members were required to sign a supervision agreement with their supervisor which outlined the frequency, duration and purpose of supervision. Inspectors reviewed seven supervision files and found that where the centre manager was supervisor, agreements were in place and signed however where the deputy manager was supervisor these had not been completed. There were also deficits in the signing of supervision records. Supervision frequency was occurring in line with policy however the recording of supervision required improvement. Inspectors noted in a number of instances there were large sections of copy and pasting of information month on month, there were inconsistencies in the discussion of placement planning depending on the supervisor and in some instances placement planning was not discussed. There was very little evidence of contribution to agendas by supervisees and there was limited use of action plans and plans for professional development. It was noted some of the above was identified in a recent audit carried out by the regional manager on the 29th July 2024 however this was the first supervision audit undertaken in the year since the centre opened thus meaning the aforementioned issues had not been identified and actioned in a timely manner.

The centre manager was supervised by the regional manager on a regular basis in line with policy. There was a clear agenda set out that both parties contributed to. The review of previous actions and setting out future actions was adhered to in order to allow for accountability. It was noted however that where discussions occurred around issues within the staff team in terms of dynamics or performance, there were no actions emulating from same and this should be reviewed in future supervisions.

It was evident that support was being offered to the centre manager through various forums such as regular supervision, blended working to ensure adequate time for administration duties. The manager also received support from a centre and deputy manager from one of the organisations other centres when required.

An annual appraisal system was in place however there were no appraisals on file due to the fact that the centre only opened in June 2023. Six monthly probation reviews had occurred and inspectors reviewed a sample of these records. A number of these probation reports identified areas of improvement and the need for additional support for individuals in certain aspects of their work. However, this requirement had not translated into supervision or training and development plans with the individuals concerned.

The organisation provided an employee assistance programme, a health insurance fund (HSF) and a budget for staff social events to manage the impact of working in the centre. Staff interviewed were aware they could access these supports as and when they felt they needed them.

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 registered provider must ensure that all staff members, including future new recruits, are trained in a model of behaviour management without delay.
- The regional manager and centre manager must ensure adequate action is taken to address non-adherence to the driving policy.
- The regional manager and centre manager should review the current handover format to ensure it meets the needs of planning for the centre in a robust manner.

- The centre manager must ensure where areas for staff practice improvement and support is identified that it translates into supervision and training & development planning.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies to Ensure Issues Do Not Arise Again
2	No action required	No action required	No action required
5	The registered provider must review the current significant event review group process and develop an effective and robust system for reviewing-significant events within this centre ensuring that staff are clear on learnings identified and changes to practice required.	The registered provider has reviewed the significant event review group process and will ensure, moving forward that all centre incidents are reviewed when completing the SERG report to identify patterns and learnings, with the report being discussed in its entirety the SERG forum. In addition, a centre specific SEN, ICSP, and Practice Guidelines will be reviewed by the group for more in-depth review. The Regional Manager will oversee and monitor the completion of the SERG meetings to ensure that the minutes accurately reflect the discussions that take place. In addition, learnings and recommendations from the review group will be communicated to the staff team through team meetings and discussed	The Regional Manager will oversee the SERG meetings and ensure that all incidents which occurred in the centre over the previous month are reviewed monthly. The Regional Manager will oversee the team meeting minutes to ensure that feedback is being provided to the staff team, recording this in their own Monthly Auditing and Governance report.

		through supervision where required.	
	The registered provider must ensure that the annual review of compliance is robust in its nature to promote improvements in work practice and to achieve better outcomes for the young people.	The centre is currently completing the Annual Compliance Report which will be completed by the end of October. The report will reflect on the centre's adherence to the National Standards and outline areas for improvement. All actions identified will be clear and measurable and will be discussed at the centre's Management Meetings to ensure that the action plans are being adhered to.	The Regional Manager will provide guidance and support the completion of the compliance report. Adherence to the action plan will be monitored by the Regional Manager and Compliance Officer and will be reported on in the Centre's monthly Compliance Report.
6	The registered provider must ensure that all staff members, including future new recruits, are trained in a model of behaviour management without delay.	There currently is only one staff member who is not trained in behaviour Management due to sick leave and who is booked to attend TCI on 05.11.2024.	As part of the onboarding process, all new staff members will be booked onto core training as soon as possible. The centre management team will complete a bi-monthly training audit from which an action plan will be developed to ensure compliance.
	The regional manager and centre manager must ensure adequate action is taken to address non-adherence to	Weekly reports are currently being provided to the centre to immediately address the non-adherence.	The Regional Manager to oversee the weekly driving reports sent to the centre and ensure that expected responses are

	the driving policy.	Supplementary supervisions have been completed with relevant staff members and associated policies discussed at a Team meeting on 09.10.2024. This combined approach has resulted in a significant improvement	being completed by the centre management team. Commentary on the approach will be added to Monthly Auditing and Governance report.
	The regional manager and centre manager should review the current handover format to ensure it meets the needs of planning for the centre in a robust manner.	The Handover Policy will be discussed at the Team Meeting on 23.11.24. This discussion will include an emphasis on the expectations as to how Handovers are to be conducted and the information required to be recorded to support shift planning. To support improvement in practice, the Regional Manager and centre management team will be present.	The Regional Manager and centre management team will monitor the effectiveness of the Handover and address any deviations through the Team Meeting and/or individual supervisions where required.
	The centre manager must ensure where areas for staff practice improvement and support is identified that it translates into supervision and training & development planning.	The centre management team have reviewed the supervising responsibilities and allocations. As part of this review, the centre manager will oversee all supervision records completed, focusing on clear recording of information in of all sections, including	The Regional Manager will discuss staff supervision and action plans during the centre manager's own supervision. The Regional Manager will ensure that the actions identified in their Supervision Audit are completed.

		training needs, and professional development, and that action plans are created at each supervision meeting, which are reviewed at subsequent supervision meetings.	