An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 014

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Focus Ireland**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**27th & 28th March 2024**
Registration Status:	**Registered from the 13th of March 2022 to the 13th of March 2025**
Inspection Team:	**Lisa Tobin** **Mark McGuire**
Date Report Issued:	**23rd May 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 and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in January 2002. At the time of this inspection the centre was in its seventh registration and was in year two of the cycle. The centre was registered without attached conditions from the 13th of March 2022 to the 13th of March 2025.

The centre was registered as a multi-occupancy emergency service. It aimed to provide a short-term placement for up to a maximum of four young people aged sixteen and seventeen years old on admission. Referrals were received through the Tusla National Out of Hours Service(NOHS) and Crisis Intervention Service (CIS). The length of stay was fourteen nights with re-referral required for longer stays. The centre operated a model of positive youth support and provided a focused service to young people unable to access alternative care arrangements. Their aim was to ensure emotional containment using trauma informed practice. 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
3: Safe Care and Support	3.3
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

At the time of this inspection the centre was registered from the 13th of March 2022 to the 13th of March 2025. This is a draft report and the decision regarding the continued registration status of the centre is pending.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 29th of April 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 13th of May 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: 014 without attached conditions from the 13th of March 2022 to the 13th of March 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 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Inspectors found that there were effective systems in place regarding the management of incidents. There were some areas that required improvement around governance oversight however in general, there were good systems in place to identify, monitor, track, and review incidents. During interviews staff were aware of their responsibility for reporting incidents and informing all relevant people when they occurred. Inspectors found that there was an open culture with the young people in the centre whereby they were informed of how they could raise any concerns they had through the use of complaints system, speaking with staff, linking with their social worker, and through Tusla's Tell Us portal. This information was outlined in the young people's booklet which they received on admission to the centre. Inspectors spoke with one young person who stated they liked living in the centre, felt safe there and felt supported by the staff team. Inspectors found there were procedures in place for shared learning among the team through team meetings, senior manager meetings, significant event review group (SERG) and at reflective practice sessions however, there were some gaps in these processes that will be addressed throughout the report.

There were mechanisms in place with the social work department about informing and contacting the parents, guardians and any other significant people involved in the young people's lives. This depended on the involvement of each of these people in the young person's life and the appropriateness of the contact. Inspectors found that parents, social workers, and guardian ad litem (GAL) were informed of incidents that occurred by phone and email and were informed when the young people were reported missing. One young person did not have an allocated social worker but had a social care worker that they linked with from the social work department. This social care worker stated they received information from the out of hours social work department around incidents that had occurred. One social worker and one social care worker informed inspectors during interviews that they were in contact with the centre regularly, they had the opportunity to give feedback and received updates on

incidents that occurred. One social worker informed inspectors that they did not receive the incident reports through the Tusla portal but that they were part of an email thread outlining that an incident had occurred. They both followed up with contacting the centre by phone and email. It became apparent to inspectors that the centre was not uploading incidents through the Tusla portal for one young person as the centre had been informed the social worker could not access this. Post inspection, inspectors were informed that the social worker was now able to access the Tusla portal and the team were in the process of sending retrospective SEN's that had not been sent through the portal. The centre management must ensure that centre policies are followed ensuring that all SEN's are sent through the Tusla portal and to the relevant people involved in the young people's lives. The social worker, GAL and social care worker all stated they were aware of the short-term placement available within this centre and felt it was a suitable placement for the young people at present and that they were safe and supported in the centre, however, they were at risk when they left the centre due to their own behaviours.

The centre had policies and procedures in place for the management of significant events. The policy and procedures outlined what was expected of the staff regarding identifying an SEN and then reporting it. The policy lacked information around the work the staff completed post incident regarding updating individual crisis support plans (ICSPs) and engagement with young people post incident to support them. Inspectors found that ICSPs were not capturing the most up to date behaviours of concern for one young person and that relevant risk assessments were not evident for the young people regarding their recent behaviours of concern. This must be reviewed by centre management to ensure all relevant information is up to date and that risk assessments are drawn up where necessary.

Incidents were recorded on an SEN register and missing child from care (MCFC) reports were recorded on a separate folder. The MCFC folder needs to be bound to ensure that the documents are not lost, and the centre manager must ensure that the register is fully completed with the relevant information entered on it. Inspectors were informed by staff that incidents were reviewed at team meetings, however in the sample reviewed there was no recorded evidence of this observed by inspectors. Inspectors did note that there were details about risk taking behaviours of young people discussed and of child protection welfare report forms being completed. As part of the agenda for managers meetings, SERG was one of the items discussed. A sample of these minutes were reviewed, and inspectors found only one reflected a SERG review occurring. Of the managers meeting minutes reviewed, there was evidence of the group establishing what the SERG should look like and achieve as a

forum for learning and development. Inspectors did not see evidence of the learning from this SERG being brought back to the team and when staff were asked about the SERG, they were uncertain about this process. Senior management and centre management must ensure that there is a documented process where staff are informed of the outcome/learnings from the SERG. There was an excel spreadsheet in place for monitoring and reviewing SENs overseen by management. There were only three SEN's noted from January 2024 to the time of this inspection in March, and it was not clear what the overall outcome was for each review undertaken. During interviews staff were able to demonstrate actions and learnings relating to a previous resident when a placement was at crisis point and they removed the young person from the centre for a brief period to stabilise the situation.

Given the nature of the emergency short term service, the main cohort of incidents reported related to the admission and discharge of young people. There were also several incidents relating to MCFC. While reviewing the SEN's, inspectors found that there were some that should have been reported as a child protection notification through the Tusla portal. The centre management and senior members of the team had oversight of the SEN's and had not identified this in their review of the SEN's prior to emailing it to the relevant people. All the staff were identified as mandated people and all staff bar one were trained as a mandated person. The identification and reporting procedures for a CPWRF must be reviewed to ensure that relevant disclosures are sent through the Tusla portal when child protection concerns arise. Improvements in oversight and governance of risk assessing and safeguarding the young people needs to be reviewed to ensure the above areas are captured on an ongoing basis.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 3.3**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- The centre manager must ensure that the missing child from care folder is bound and fully completed with all the relevant information.
- The centre management must ensure that centre policies are followed ensuring that all significant events are sent through the Tusla portal and to the relevant people.
- The centre manager must ensure that risk assessments are up to date and in place for relevant new behaviours of concern. This must also be reflected in the young person's individual crisis support plan.
- The registered provider must ensure that there is a consistent process in place for reviewing incidents.
- Senior management and centre management must ensure that there is a documented process where staff are informed of the outcome/learnings from the SERG.
- The centre management must ensure that the identification and reporting procedures for a CPWRF are reviewed with staff to ensure that relevant disclosures are sent through the portal when child protection concerns arise.

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.

Inspectors found that there were processes in place to ensure the quality and safety of care and to identify improvements of care within the centre. There was a focus on risk management in this centre given the purpose and function of emergency placements. Staff usually had little knowledge of the young people's social history or backgrounds before they were admitted to the centre and therefore had systems in place to mitigate risks in their processes for admission. Outlining the potential risks and knowing how to respond to them was an area focused on with the staff on an ongoing basis to ensure consistency across the team.

Planning meetings and strategy meetings occurred for the young people to address move on plans and, to discuss any risks or areas of support required. When there was an increase in a risk behaviour, these meetings became more frequent and had

relevant people from the social work department, external support services and An Garda Siochana in attendance.
Inspectors found that the communication between these services and the centre was paramount to effectively plan how to keep the young people safe.

There was a quality assurance officer in place that undertook audits in the centre against the National Standards for Children's Residential centres (HIQA) 2018. The last audit provided to inspectors was from September 2023 and focused on elements of themes 2, 3, 5 and 6. This audit found there were issues that required follow up and it was unclear to inspectors if these were completed and who was responsible for overseeing them. There was a quality improvement plan and audit tool provided to inspectors which incorporated recommendations from 2020 to 2023. This document and the processes used for this audit tool required improvement as tasks were incomplete, some tasks had no person named for completion and there was a lack of evidence of how or when the actions were undertaken.

Inspectors were informed there had been no complaints since the last inspection in February 2023. However, when reviewing the young people's files inspectors saw where young people had made complaints, and that they were not responded to in line with policy. Inspectors were informed by management that due to one young person being missing from their placement, it was difficult for staff to follow up on their complaints. As staff were advocates for the young people, there were processes that could have been undertaken in line with their policy, such as engaging with the centre's complaints policy, using Tusla's Tell Us complaints portal or contacting the Ombudsman for Children.

The Annual Service Review was taking place with the staff team, management, and the Head of Youth Services while this inspection was taking place. The minutes were forwarded to inspector's post inspection. The Annual Service Review captured the purpose and function of the service, the numbers of young people they supported throughout 2023 and a number of statistics relating to care information. There were recommendations attached with assigned responsibilities and times for completion. Given that placement extensions had become more frequent, the centre was focused on using their escalation system to achieve adherence to their registered purpose and function.

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

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 5.4**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- The registered proprietor must ensure there are effective quality improvement plans and audit systems in place with clear actions and named persons responsible for completion of tasks to ensure better outcomes for young people.
- The centre manager must ensure that the centre policy and procedures are followed if the young people make a complaint.

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.

The staff in the centre were aware of their roles and responsibilities as noted by inspectors during their interviews. They spoke of a close team who supported each other, and reported this created a good working environment. The staff knew what they were accountable for and who to report to if they had any issues or concerns. The staff stated they had received training in the policies and procedures and were aware of the expectations in their role. As noted previously, inspectors recommend staff receive refresher training on the centres policy on reporting CPWRF's as well as the complaints policy.

All staff stated they were given opportunities to exercise their professional judgement and supported around any decision that they made on shift. The centre manager spoke of empowering the team and using role modelling to encourage development within the team.
The staff spoke of the support received from the centre management in developing the staff team and guiding them in their daily practices.

The centre attempted to be proactive in their response to risk if they had prior knowledge of the young people, risks were identified to the team regarding the current young people through sharing of information with another sister service. Risk responses were put in place for staff to manage certain situations with the young people, for example, money was an identified trigger for a young person, the centre no longer holds any cash on the premises which eliminated that risk. The staff identified strong links with the local Gardai. When support was required for the staff with managing concerning behaviours, Gardai were contacted.

Staff identified supports available to them to enhance the delivery of effective care which included ongoing training, reflective practice with an external facilitator, regular team meetings and access to supervision. During interviews staff described a culture of learning within the centre, emphasising support as they advance in their roles, the acceptance of making mistakes, and the subsequent learning from them. There was a management structure within the centre that supported this process from social care workers to social care leaders, deputy manager and centre manager.

There was a supervision policy in place however it did not outline how often supervision was to occur. During interviews with staff, inspectors were informed this was every 4-6 weeks. Inspectors reviewed a sample of supervision records and found that some supervisions were not occurring within this period. Delays were identified in the records such as annual leave, sick leave or due to crossover of shifts.
Inspectors found that more recent supervisions had better detail but overall, these could be structured better. Some records were illegible as they were handwritten.

Appraisals were being re-introduced this year, there had been none undertaken yet but there were dates in place for this to commence. Staff had access to an employee assistance programme. They had access to counselling and a wellness centre. They stated they found supervisions and reflective practice beneficial to their development. The staff also stated that the reason they remain working in the centre was down to the team, the support from management and the young people that they get to work with.

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

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 6.3**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- The centre manager must ensure that a policy review is undertaken to ensure a timeline for supervision is in place in line with best practice to support the development of the staff and that supervision records are structured and legible.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure that the missing child from care folder is bound and fully completed with all the relevant information.	New professionally bound MCFC folder now in place (April 2024).	Ensure new book ordered from printer before the current book is completed. Assigned to a SCL.
	The centre management must ensure that centre policies are followed ensuring that all significant events are sent through the Tusla portal and to all the relevant people.	A letter outlining service has been amended which now contains details on how Tusla staff gain access to SEN's via the Tusla Portal (April 2024).	Raised at planning meeting to ensure SWD has registered and obtaining SEN's.
	The centre manager must ensure that risk assessments are up to date and in place for relevant new behaviours of concern. This must also be reflected in the young person's individual crisis support plan.	A redesign of the process has occurred whereby ICSP and risk plans are merged in to one new document. This has been trialled and received feedback from staff as working as in reduces error rates by having only one document. (April 2024)	Refreshment on risk support management with whole team 29/05/2024 by SCM. Audit of YP folders to ensure up-to-date and useable plans completed by SCL once a month.

	The registered provider must ensure that there is a consistent process in place for reviewing incidents. Senior management and centre management must ensure that there is a documented process where staff are informed of the outcome/learnings from the SERG. The centre management must ensure that the identification and reporting procedures for a CPWRF are reviewed with staff to ensure that relevant disclosures are sent through the portal when child protection concerns arise.	Incidents management has been revised for Monthly Management Meeting. (April 2024) SERG feedback to Team will occur quarterly as well as Team SERG been carried out quarterly at the Team Development Morning (last Wednesday of every month). Staff will be nominated to present a SEN every 3 months. Review of CPWR to occur at full in person team meeting on 15/5/24 and within supervision.	Audit on managers meetings completed by the safeguarding and governance manager every four months. Listed on agenda for meetings which are already planned until the end of December 2024. Supervision Audit will ensure that it has been addressed. CPWR standing item at Team Meeting. SEN reviews at management meeting asks if there is a CPWR required, and the rationale will be documented within the minutes.

5	The registered proprietor must ensure there are effective quality improvement plans and audit systems in place with clear actions and named persons responsible for completion of tasks to ensure better outcomes for young people. The centre manager must ensure that the centre policy and procedures are followed if the young people make a complaint.	Audits are listed out for 2024 with follow up meetings in place with Centre Management and Safeguarding & Governance Manager. Review of complaints policy at team meeting has occurred on 2/5/24.	QIP reviewed monthly at Centre Management Meeting and standing Item on agenda. Review Complaints Policy once per year at team meeting.
6	The centre manager must ensure that a policy review is undertaken to ensure a timeline for supervision is in place in line with best practice to support the development of the staff and that supervision records are structured and legible.	New format for supervision record keeping in place.	Audit of supervision by Head of Youth Services annually.