An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 049

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**14th & 15th November 2023**
Registration Status:	**Registered from 05th of March 2022 to the 05th of March 2025**
Inspection Team:	**Lorraine Egan** **Eileen Woods**
Date Report Issued:	**16th January 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 March 2012. At the time of this inspection the centre was in its fourth registration and was in year two of the cycle. The centre was registered without attached conditions from 05th March 2022 to the 05th of March 2025.

The centre was registered as a multi occupancy short to medium term centre catering for up to four young people of mixed gender between the ages of sixteen and nineteen years of age on admission. Its specific purpose was to prepare young people for leaving care, independent living, and adulthood. The model of care was based on the systemic therapeutic engagement model (STEM) which was described as providing a framework for positive interventions with young people. It supported the development of relationships which focused on achieving strength based outcomes through daily life interactions and targeted programmes. It draws on a number of complementary philosophies and approaches including Circle of Courage, Response Abilities Pathways, Therapeutic Crisis Intervention and Daily Life Events. There were four young people living in the centre at the time of the inspection, one of whom was over 18.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.3
3: Safe Care and Support	3.2
5: Leadership, Governance & Management	5.4

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 27th November 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 11th December 2023. This was deemed to be unsatisfactory and a second CAPA with further supporting documentation of the issues addressed was submitted on the 19th December 2023 and was accepted by ACIMS. As a consequence of the additional evidence provided the final report was changed to reflect that regulation 16 of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 had been met by the centre.

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: 049 without attached conditions from the 05th March 2022 to the 05th of March 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.3 Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.

The centre's purpose was the provision of semi-independent living programmes for young people including support with moving on from care. From a review of centre files and interviews with staff, inspectors found that in general, young people's voices were reflected in the decisions being made about their own care planning. Very soon after they moved into the centre a consultation session with each young person was put in place to identify their placement goals. They were asked for their views on their immediate and future needs so that work could begin on individualising a skills programme relevant to the stage and age they were at. This opportunity for young people to give their opinions on issues that mattered to them was implemented in response to the findings of the inspection in 2022. While most placement plans were representative of young people's contributions, improvements were required in the consistency of the recording of their input as some documents better reflected young people's voice more clearly than others.

Placement plans were reviewed monthly by key workers and these outlined short and long term goals which were in the main focused and meaningful. A number of care plans were not present on young people's records at the time of the inspection as they had not been forwarded by the placing social work departments. Some evidence of requests to source these were on file but the escalation of the deficits by senior management was not observed on the documents reviewed. Each young person had a key worker and these were assigned as soon as they moved in to the centre. Inspectors were told that there was an option to alternate key workers at any time depending on the young person's own choice.

Shortly after admission, young people were given information as part of one to one sessions with the staff team which included the rules for living in the apartments, routines and expectations and how to make complaints. Although attendance varied each week, house meetings were also taking place and young people's input was

clearly represented on the minutes. If young people chose not to attend, one to one work was planned to find out their views and thoughts. Agenda items included daily requirements such as shopping and menu planning and any maintenance problems relating to individual apartments. Certain issues were categorised to bring to the staff team meetings for further discussion but from a review of minutes, this was not occurring. Where resolutions were agreed by the staff team on the various items raised, there was an absence of recording on the young people's files of regular follow up with them. Other areas addressed at young people's meetings included the emergence of negative relationships between each other and recognising mutual respect and boundaries between the group. There was evidence of some changes to rules too when voiced by the group. For example, money resourced for young people's activities was agreed for use for an alternative purpose when requested.

Information was shared by the staff team about advocacy services such as Empowering Young People in Care (EPIC) and the right to read their own records maintained by the centre. However, staff at interview described an onerous process involved in their access. The young people's booklet was also provided at this time but there was an absence of information on services such as the Ombudsman for Children's Office as well as Tusla's 'Tell Us'. Inspectors recommend that this is included at the next update of the booklet. Despite this, it was evident from young people's files that the staff team were advocating consistently on their behalf regarding issues such as increased family access, resources for and referrals to external clinical services, education, employment, accommodation and appropriate and timely medical care.

Inspectors found evidence that the team had formed supportive relationships with young people through their daily interactions and weekly plans. Despite the independent living function of the centre, communication between the staff team and young people was regular and appropriate to their health, wellbeing and daily needs. Each young person was making progress within their specific leaving care programme and where there were periods of disengagement because of being missing from care or other reasons, staff were quick to respond and reconnect with them at their own pace. Regular one to one sessions and key working was taking place and staff checked in with the young people frequently when they were in their apartments. Social workers told inspectors that the team showed a sense of care, regard and openness in the way they connected with young people.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 1.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- Centre management must ensure that young people's contributions to decisions made about their care are consistently reflected across their records.
- Centre management must ensure that issues raised by young people at group meetings are brought to staff team meetings for discussion and decisions made recorded on the minutes. Follow up with young people should be consistently taking place.

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

Theme 3: Safe Care and Support

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

The centre had a policy in place that outlined how staff were to respond to young people whose behaviour may be challenging. It showed an understanding of the impact of trauma and harm on young people and how this may affect them in various ways in their daily lives. It was underpinned by allied policies and interventions including, the significant event notification (SEN) policy, risk assessment and management, child safeguarding, physical intervention and the sanctions policy. It also reflected the systemic therapeutic engagement model of care (STEM) and inspectors saw evidence of its use in practice with young people across their records.

The staff team received training in behaviour management and how to respond to young people's crisis incidents. Certification for this programme was up to date for

seven out of nine staff, however, this was booked and scheduled to be completed for the remaining team members. The STEM model of care programme had been provided too and any gaps remaining were booked or soon to be scheduled. Staff described the model well at interview and could align it to their everyday practice with young people. Ancillary training such as ligature training was part of the core programme for the staff team and they stated that where specialist courses were requested by them, they were responded to positively by centre and senior management.

Staff showed good knowledge and awareness of young people's individual vulnerabilities and risks and there were a number of supporting plans in place to mitigate their impact and reduce the number of crisis incidents. These included individual crisis support and practice plans, (ICSPP), risk assessments and absent management plans. However, some of these supporting documents were not consistently on all young people's files and it was not clear if they were reviewed and updated after a significant incident took place.

Further, the interventions and strategies within the ICSPP's were hard to follow. For example, the responses contained within were overarching and did not specifically relate to each behaviour or risk identified. While the risk assessments outlined a number of techniques to implement, in some cases, the steps to be followed by the team were vague and required more detail particularly relating to self-harm and suicidal ideation.

Despite this, inspectors found that the staff team were swift to intervene when issues and crisis situations arose for young people. Staff had good bonds developed and the individual trusting relationships contributed positively to the prevention of harm and a reduction in their challenging behaviours. Garda protocol meetings were coordinated appropriately and social workers spoke of positive collaboration and joint working when incidents increased. Safety plans were implemented at times of prolonged episodes of missing in care, and heightened concern and referrals were made to appropriate external specialist services. Key working opportunities were undertaken to support young people to understand the impact of risks and behaviour that challenged.

Sanctions were applied and a written warning system was also in place. However, the purpose of both was difficult to follow. From a review of individual records, young people had voiced how the impact was causing confusion and they were dissatisfied with the outcome after raising issues about warning letters received and the length of

time consequences were in use. There was no record on centre files of a review of the system for each young person and there was an absence of feedback provided to them. In addition, these dissatisfactions had not formed part of the centre's complaints process. For example, the ongoing use of a specific sanction for one young person where it was implemented to reduce their missing from care incidents was not proving effective. The young person involved had raised their opposition to its use many times and there was no complaint recorded on centre records. Also, the multiple warnings on file for individual young people had no end date and were on occasion communicated to young people at inopportune times by any member of the staff team.

A sample of significant event notifications (SENs) were reviewed, and inspectors found in some cases these were not notified in a timely way to social workers. Also, the forms did not indicate if they were submitted to Tusla's SEN team. However, post inspection, the centre manager forwarded evidence to ACIMS showing that Tusla's portal system was inoperative at that time and the team had been alternatively informed by email of the significant events for the specific period sampled. At interview, some allocated social workers said they noted delays in receiving SENs but were satisfied that as soon as an incident took place, the centre manager made contact by phone and email to update them on the young person.

Missing Child In Care forms (MCIC) were not regularly maintained on young people's files and it was also hard to track individual SENs with the specific incidents logged on the SEN register. Significant event review group meetings (SERG) were regularly undertaken but key learning was not clearly recorded and this should be improved and shared with the staff team. Attempts at life space interviews were on centre records for some young people but this was not a routine practice after an SEN had occurred.

~~A~~uditing was undertaken both internally and externally by the organisation's compliance officer. This included monitoring of the centre's managing behaviour that challenges framework and it identified goals for growth, areas of strength and timescales for completion of actions. Some of the gaps identified in the audits remained in consecutive reports without being addressed and in part relate to the findings from this inspection.

There were a number of restrictive practices in place in the centre and any risk assessments developed for review purposes were out of date. Not all restrictive practices currently in use were recorded on the young people's care record or

monitored on an ongoing basis in line with centre policy and this should be addressed. The restrictive practice policy had been updated in response to one of the findings on room searches from the 2022 inspection.

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	**3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- Centre management must ensure that all behaviour support plans are consistently updated and on file for all young people. Improvements are required so that interventions outlined in the supporting documents are clear and easy to follow in practice.
- Senior and centre management must ensure that the warning and consequences system in place is reviewed for use with young people. Young people's dissatisfactions in relation to behaviour management approaches in use in the centre should be managed under the centre's complaints system.
- Centre management must ensure that all SENs are fully completed and reported in a timely way to all appropriate professionals. MCIC forms should be maintained on each young person's file. SENs should be aligned clearly on the centre's register with young people's individual completed forms.
- Senior management must ensure that learning from SERG meetings are clearly documented and shared with the staff team.
- Centre management must ensure that all restrictive practices in use are recorded on the young people's care record and monitored on an ongoing basis in line with centre policy.

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.

There were a number of governance systems in place in the centre to monitor service provision and to ensure that care was delivered in a safe and effective way for the young people living there. Regular auditing was taking place both internally and externally against the National Standards for Children's Residential Centres, 2018 (HIQA). An annual report of compliance had been developed too and monthly governance reports containing an overview of risks, child protection concerns, and complaints were delivered by centre management. In addition, regional manager audits had taken place throughout the year. Other forums in place to contribute to improvements for young people included significant event review group meetings, young people's meetings, weekly team meetings and senior management meetings. Despite this it was not clear how learning from these review mechanisms was shared consistently with the staff team so that improvements could be implemented.

As mentioned in the report, progress was made on achieving better outcomes since the last inspection of 2022. Gaps were addressed regarding the restrictive practice policy as well as the introduction of care planning consultation sessions with young people.

However, further improvements are required. These include the completion of all corrective actions from the deficits captured in the external auditing and compliance reports. Some of the timelines for the identified actions had been extended throughout consecutive audits. Inspectors found a number of gaps also regarding the tracking of child protection and welfare referrals submitted. These were logged in the SEN register and were difficult to navigate and align to the number of reports and child safeguarding concerns documented on young people's files. In addition the centre manager has not yet completed designated liaison persons training (DLP) and this should be scheduled as soon as possible.

The management of complaints formed part of the actions required from the 2022 inspection, specifically relating to the responses, recording, management, and oversight of complaints. While the commitment to update the policy was completed,

and some improvements were made on responding to complaints, additional work is required to capture and reflect all dissatisfactions from young people under the centre's policy. From a review of the young people's files and the complaint's register, inspectors found that gaps remained in similar areas and not all complaints or dissatisfactions were fully responded to. In some instances the staff team made efforts to have conversations with young people relating to what they were unhappy about but these were not always reflected as resolved on centre files. A record should be maintained of all complaints/dissatisfactions, including details of the investigation and resolution. Young people have a right to be informed of the outcome and their response recorded on their file. Learning from trends identified should be communicated to staff.

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

- Senior management must ensure that all corrective actions from the deficits identified in the centre's auditing and monitoring system is completed.
- Centre management must ensure that child protection and welfare referrals are clearly logged in the centre register so that they can be consistently monitored and analysed.
- The registered provider must ensure that specific designated liaison person training (DLP) is completed by the appointed DLPs.
- Centre management must ensure that a record is maintained of all young people's complaints/dissatisfactions, including details of the investigation and resolution. Young people have a right to be informed of the outcome and their response recorded on their file. Learning from trends identified should be communicated to staff.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	Centre management must ensure that young people's contributions to decisions made about their care are consistently reflected across their records. Centre management must ensure that issues raised by young people at group meetings are brought to staff team meetings for discussion and decisions made recorded on the minutes. Follow up with young people should be consistently taking place.	Each young person will be offered the opportunity to have input into the development of monthly placement plan, which will be recorded and attached to each document. Where a young person chooses not to engage, the efforts made by the staff team, will be recorded. Implemented – 8th December 2023. A review of the young person's meetings was completed by the centre Management Team on 04.12.23. Where information on feedback from the team meeting was not recorded, this was added. The team meeting template was updated to prompt review of young people's meeting at each team meeting. Implemented 8th December 2023.	The completion of monthly consultation with young people will be overseen by the case manager and reported in the centre's monthly governance report. The compliance officer will review these reports and provide commentary of the adherence to this expectation on a monthly basis. As part of the standing items of the team meeting, items raised at the young person's meetings will be discussed and minuted. The centre management team will review the young person's meeting records on a monthly basis and ensure that feedback is explicitly recorded.
3	Centre management must ensure that	A review of all placement plans was	The centre management team will

	all behaviour support plans are consistently updated and on file for all young people. Improvements are required so that interventions outlined in the supporting documents are clear and easy to follow in practice.	completed by the centre management team on 05.12.23 to ensure that there was clear plans and interventions in place relevant to the behaviours of each young person. The completion of placement plans was discussed at a team meeting on 04.12.23, where guidance on the completion and updating of forms was discussed.	complete a review of all placement plans on a bi-weekly basis. Where incidents occur which require a review and update of the placement plans, the completion of this will be recorded as management comments. In addition, the regional manager will complete an audit on placement planning in the centre, which will include a review of daily logs, handovers, MPR, SENs YP files etc.
	Senior and centre management must ensure that the warning and consequences system in place is reviewed for use with young people. Young people's dissatisfactions in relation to behaviour management approaches in use in the centre should be managed under the centre's complaints system.	All warnings and consequences will be recorded on sanction reports, which will also record the young person's response, the completion of which will be reviewed by the centre management team. Where there is dissatisfaction expressed by the by the young people, the complaints process will be applied. Implemented 8th December 2023.	The centre management team will review all sanction reports and report their findings in the centre's monthly governance report. In addition, the regional manager will complete an audit on complaints in the centre, which will include a review of other documents to ensure that the young people are being responded to in an appropriate and timely fashion.
	Centre management must ensure that all SENs are fully completed and reported in a timely way to all appropriate professionals. MCIC forms	The centre management team will discuss the completion of SEN's at the centre's management meeting on 04.12.23 where deficits in reporting will be discussed. Any	The regional manager will continue to oversee all SENs sent from the centre, and where reports are incomplete or there are delays in sending SENs this will be

	should be maintained on each young person's file. SENs should be aligned clearly on the centre's register with young people's individual completed forms.	SEN that continues for longer than 24 hours an update is provided to all professionals via email and the CRS team is updated via the Tusla portal. New SEN checklist is implemented to ensure all documentation is in place and accounted for. Implemented from the 28.11.23. For example staff must tick off that the MCIC form is attached to the SEN, the email is attached & IWR completed. The SEN register will be reviewed by centre management on a bi-weekly basis to ensure SEN's match the register.	addressed with the centre management team. In addition, the regional manager will complete an audit on placement planning in the centre, which will include a review of daily logs, handovers, MPR, SENs YP files etc. The regional manager will also sign off on the SEN register to ensure all SEN's match the register. Monthly review of SENs is discussed and documented in the regional SERG meeting minutes.
	Senior management must ensure that learning from SERG meetings are clearly documented and shared with the staff team.	The Centre Manager will ensure that Regional SERG review meetings are brought to team and management meetings and explicitly recorded in the centre's meeting minutes. Implemented 8th December 2023.	The regional manager will review team meetings which occur after SERG meetings to ensure that feedback from these meetings is clearly recorded.
	Centre management must ensure that all restrictive practices in use are recorded on the young people's care record and monitored on an ongoing	The centre manager completed a review of all instances of restrictive practices on 05.12.23 to ensure that they are accompanied by a sanction or risk	The centre management team will review all reports relating to restrictions on a monthly basis and record their findings in the centre's Monthly Governance Report.

	basis in line with centre policy.	assessment form. The centre manager will also ensure that all instances of restrictive practices are discussed and updated on a regular basis.	
5	Senior management must ensure that all corrective actions from the deficits identified in the centre's auditing and monitoring system is completed. Centre management must ensure that child protection and welfare referrals are clearly logged in the centre register so that they can be consistently monitored and analysed. The registered provider must ensure that specific designated liaison person training (DLP) is completed by the appointed DLPs.	A full review and evaluation of all audits is scheduled to be completed in December 2023, which will include the tracking of identified deficits. Regional manager will ensure corrective actions are addressed. The centre management team completed a review of the SEN register on 30.11.23 and ensured that all CPWRFs were recorded and easily identifiable. The centre manager will complete a full review of training, including DLP training in December 2023. DLP Training is booked in for the 23.01.24 for centre management. Where deficits are found, courses will be booked or escalated as	The revised auditing system will be implemented from January 2024, which will incorporate all levels of oversight. The tracking of actions identified, and their resolution will be completed by the quality assurance manager. The centre management team will review the SEN register when completing centre's monthly governance report. In addition, the regional manager will complete an audit on child protection in the centre in 2024. The centre management team complete bi-monthly training reviews to identify any training gaps and where courses are unavailable, they will be escalated and requested through the regional manager.

	Centre management must ensure that a record is maintained of all young people's complaints/dissatisfactions, including details of the investigation and resolution. Young people should be informed of the outcome and their response recorded on their file. Learning from trends identified should be communicated to staff.	being required. The centre manager will discuss the complaints policy at the team meeting on 04.12.23 focusing on the application of the policy and the expectations around recording the response to the young people including their level of satisfaction to this response. The complaints folder is to be reviewed and monitored bi-weekly by the centre management team to ensure that a record is maintained of all young people's complaints. Any learning from complaints by the young people should a pattern be identified must be updated into the ICSPP for the young person. Complaint feedback/ outcome with the young person must be documented via an IWR or through the complaints procedures and communicated clearly with the young person.	The regional manager will complete an audit on complaints in 2024, which will include a review of other documents to ensure that the young people are being responded to, are provided with feedback and that their level of satisfaction is clearly recorded.