An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 095

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Daffodil Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**23rd, 28th & 29th August 2023**
Registration Status:	**Registered from 30th December 2023 to the 30th December 2026**
Inspection Team:	**Linda Mc Guinness** **Lorna Wogan**
Date Report Issued:	**18th December 2023**

Contents

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 2008. At the time of this inspection the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from the 30th December 2020 to the 30th December 2023.

The centre was registered as a multi occupancy service. It aimed to provide short to medium term care for four young people from age thirteen to seventeen years. 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 four young people living in the centre at the time of inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1
4: Health, Wellbeing and Development	4.2
6: Responsive Workforce	6.3

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

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff, and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 16th of October 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 31st October 2023. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 095 without attached conditions from the 30th of December 2023 to 30th of December 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 3: Safe Care and Support

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

The centre had a safeguarding and child protection policy that was dated December 2021. The inspectors were informed that this policy was currently being revised and would be approved and circulated imminently. The inspectors found that many aspects of the policy complied with Children First: National Guidance for the Protection and Welfare of Children, 2017 and relevant legislation. Notwithstanding this, repeated deficits in aspects of the written policy and procedure were identified in the course of inspections across the wider organisation in relation to the management of allegations that had not been rectified to date.

There was a system in place whereby preadmission individual and impact risk assessments were developed prior to admission to identify and respond to any areas of individual vulnerability including the potential risks within a group dynamic. Social workers confirmed that they were consulted during this process.

Other policies to protect and safeguard young people from harm included staff recruitment and selection, risk management, training, child sexual exploitation, bullying, a code of practice and protected disclosures. As required, a child safeguarding statement was displayed in the centre that was dated January 2022. However, the inspectors found that this statement did not contain all relevant and potential risks of harm as it did not specifically include the risk of child sexual exploitation (CSE) or the relevant Tusla CSE checklist and reporting procedure and a control measure to manage this specific risk. The registered proprietor was identified on the child safeguarding statement as the Designated Liaison Person (DLP) however this role on the statement was delegated to another person who no longer worked in the centre.

The inspectors found that the practice of delegating the role and responsibilities of the DLP to the centre managers was unclear and created confusion amongst staff

about who ultimately held responsibility for this role. This was evident in interviews with both staff and managers in the centre. This matter was raised in the course of recent inspections within other centres operated by the provider. Additionally, there was lack of clarity who was the appointed deputy DLP. Most staff interviewed stated they would go directly to their centre manager for advice or guidance in relation to a child protection concern even where they identified in interview that the registered provider was the DLP. There must be absolute clarity on who holds the role and responsibility of the DLP and the child safeguarding statement must be updated to contain the additional risk as identified by the inspectors.

Following a review of personnel files and training records the inspectors found that all staff received training in the Tusla e-Learning module: Introduction to Children First, 2017 and additionally staff attended external child protection training. There was evidence that child protection and safeguarding policies were discussed at team meetings. Inspectors found however, that staff interviewed (including those holding senior positions) were not confident and lacked clarity about the child safeguarding statement and in their knowledge of child protection legislation, policies and procedures in respect of safeguarding. Staff were not familiar with the purpose of the child safeguarding statement, its legislative basis, the risks of harm identified on the statement or the control measures in place to mitigate identified risks. Additionally, for some staff interviewed there was confusion between disclosures of abuse and protected disclosures.

The inspectors found that staff interviewed were not familiar with Tusla's Child Sexual Exploitation (CSE) Procedure, 2021 for submitting concerns about CSE to Tusla and An Garda Síochána. This issue was a concern at the time of inspection. While information on CSE was incorporated into the centres safeguarding and child protection policy staff had not yet completed the Tusla e-Learning training in respect of CSE or Tusla e-Learning training on the role of mandated persons.

The senior managers must ensure they are satisfied that all staff understand the policies, procedures and training and can implement them effectively.

The centre manager maintained a list of all mandated persons in the centre. Despite the deficits identified in the centres child safeguarding policy staff interviewed were aware how to report any concerns of harm or abuse. All staff were registered on the Tusla portal to facilitate reporting child protection or welfare concerns arising. They were aware of their statutory responsibilities as mandated persons.

The centre maintained a record all reported child protection concerns and these were highlighted and tracked through the significant event register. There was a file for recording concerns, and these were filed with all appropriate documentation. The manager provided and sought regular updates from supervising social work departments in relation to final outcome of reports. Following a review of care records inspectors were satisfied that four identified child protection concerns were appropriately managed and reported for young people living in the centre since the last inspection of this service in June 2022.

The inspectors also found that a more robust and coordinated safeguarding response was required in relation to one of the identified vulnerabilities. Staff interviewed by the inspectors did not identify specific vulnerabilities for the young people that were subsequently identified by the inspectors on their review of care files. While the primary concern was reported, inspectors found that subsequent concerns arising were not notified as significant events and no evidence of assessing it in terms of meeting the threshold for a mandated report or to monitor and track it as an issue that did not meet the threshold for reporting. There was no specific safety plan in place to manage the concern. Inspectors found that a request from the social work department to conduct random phone checks was not followed up. Inspectors were informed by staff and management that phone checks only took place if there was reasonable cause for concern and there were no records of phone checks being undertaken. Inspectors spoke with the social worker who confirmed that this response did not correspond with their direction to ensure appropriate safeguards were in place.

Child protection was included as a standing agenda item for each young person at team meetings however minutes did not evidence clear safety planning in respect of all the vulnerabilities identified. Monthly governance reports completed by the centre manager included a review of child protection reports and these were read and reviewed by the regional manager. While this oversight was positive and helped to track outcomes, the deficits in safety planning was not identified following review and oversight of the centre reports.

The inspectors reviewed the young people's care files and found that key working and individual work was undertaken to include relevant topics such as internet and phone safety, consent, sexual health, and healthy relationships. Staff were creative and used various resources to engage young people which provided research based educative content. The team and key workers were proactive and provided general information to young people to develop the skills needed for self-care and protection. However,

improvements were required on placement planning documents to identify specific interventions to meet identified goals or address specific concerns and facilitate learning.

Inspectors reviewed a sample of personnel files and overall found that safe recruitment practices were in place and the staff recruitment selection policy was adhered to. Staff files reviewed contained appropriate Garda and overseas vetting where required. There was evidence and verification of qualifications and three written verified references for each staff. However, in the case of one staff member a reference was provided by the same person who was identified on the personnel file as the staff member's next of kin, this was not in line with organisational policy or safe vetting practices.

The suite of policies contained an anti-bullying policy and procedure. Staff were aware of the signs of potential bullying and the policy indicated a child protection report would be made through the Tusla portal if bullying met the threshold of harm as defined under Children First: National Guidance for the Protection and Welfare of Children, 2017. There was no reported incidence of bullying amongst the young people since the last inspection of this centre in June 2022. Young people who provided feedback to inspectors identified staff they could speak to and said they felt safe living in the centre. Social workers also indicated that the young people had trusting relationships with identified staff who they could approach if they needed advice or support.

The service had applied for and successfully achieved an award to evidence the positives steps they have taken as an organisation to respond to and prevent bullying. Full implementation of this programme was in progress at the time of inspection.

The centre's CSS, safeguarding and anti-bullying policies highlighted the risks for young people associated with the use of social media and access to the internet. There was evidence that staff provided the young people with appropriate information to equip them with the knowledge and skills to protect themselves online. At the time of the inspection two of the young people had age-appropriate restrictions on their use of technology. This was agreed in consultation with allocated social workers. Following concerns raised during inspection, and subsequent communication with the supervising social work department when new concerns were identified for one of the young people, restrictions on their phone technology were applied to ensure appropriate safeguarding. There was evidence that where

concerns existed that staff addressed these with young people in an open and transparent manner and explained the reasons for any required safety interventions.

Aside from the issue described above relating to phone checks, there was evidence that the centre worked in partnership with social workers, other relevant professionals and families where possible to promote the safety and wellbeing of all young people.

There were agreed procedures with social work departments to inform parents of any allegations of abuse where appropriate.

The centre had a protected disclosures policy and procedure that outlined the procedure for staff to follow to disclose any wrongdoing within the organisation that came to their attention. Despite evidence that the policy was discussed at a team meeting there was some confusion as previously highlighted between this policy and the safeguarding and child protection policy. Inspectors did not find that there was a culture whereby all staff were confident to call out poor practices at the time of inspection. For example, in one instance an issue that was brought to the attention of a senior member of staff was not escalated appropriately until another member of staff reported it. Inspectors found that there was not sufficient evidence of follow up with staff if they did not follow policies.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this Theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Not all standards under this Theme were assessed**

Actions required:

- The registered provider must ensure the child safeguarding statement and the safeguarding and child protection policy is updated as a matter of priority and satisfy themselves that all staff understand and implement these correctly in practice. Staff must be familiar with the risk assessment on the CSS.

- The registered provider must ensure that there is absolute clarity on who holds the role and responsibility of designated liaison person.
- The registered provider must update the ensure that staff undertake the Tusla e-Learning training on the role of mandated persons in line with the organisations' safeguarding policy. They must update the policy to include the Tusla national policy and reporting procedure in respect of child sexual exploitation and ensure staff undertake this training.
- The registered provider must ensure that where specific vulnerabilities are identified for young people that a robust and co-ordinated response is implemented. Specific safety plans must be devised and reviewed and the direction of social workers followed to ensure appropriate safeguards are implemented.
- The registered provider must ensure that all vetting procedures are in line with organisational policy and safe vetting practices.
- The registered provider must ensure that staff are fully familiar with the whistleblowing policy and their obligations to report poor practice.
- The registered provider must ensure there is evidence of accountability where policies and procedures have not been implemented.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

Inspectors found that the management and staff team prioritised the health and wellbeing of the young people to support them to reach their full potential. There was a policy on 'general physical health' that aimed to create an environment to promote healthy living and discourage activities that may be harmful to them. This policy included exercise, diet and nutrition and smoking. The inspectors recommend the policy is updated to include sexual health, substance misuse awareness and mental health and wellbeing for young people. There was evidence that staff made efforts to support positive daytime and sleep routines.

The centre was awaiting two updated care plans following recent child in care reviews. Inspectors reviewed the care plans and placement plans on file and found that they identified the health and development needs of each young person. Social workers who spoke to inspectors were satisfied that all health and development needs

were addressed in line with care plans and that the management and team advocated for specialist supports for young people. They confirmed that the young people they were supervising were facilitated to attend dental, optical and other relevant medical appointments. One young person missed a number of appointments due to staff errors/omissions and this was addressed at both team and management meetings. There were systems identified and in place to prevent a reoccurrence of this issue. Young people were involved in their medical care and their individual preferences were considered.

A review of young people's files evidenced that relevant records of medical and specialist assessment reports were maintained. Three of the young people had records of childhood immunisations and the centre was awaiting these records for a young person recently admitted. Young people were encouraged to uptake optional vaccinations such as HPV and Covid 19. Each young person had a medical card and signed medical consent forms on file as appropriate. All young people were registered with a local general practitioner and received prompt medical attention where required. Inspectors found written confirmation from their G.P's approving pro re nata (PRN) medications such as antihistamines, cough medication, lotions and creams and age-appropriate paracetamol-based medications.

The staff team utilised resources to teach young people about their health and wellbeing. There was evidence that the team were strong advocates for specialist supports for the young people where required. There was a significant delay in sourcing an assessment for one young person and inspectors found evidence that staff advocated and communicated with the relevant social work department until the assessment was approved and undertaken.

Individual health issues of a sensitive nature were managed thoughtfully keeping the young people at the centre of these discussions. There was appropriate sharing of information to support young people and plan effectively. There were appropriate responses to individual needs and evidence that the team followed the advice and recommendations of clinicians/specialists. Staff received training in the safe administration of medication and additional training in the management of specific medical needs.

The care files and key working records evidenced individual work undertaken with the young people that included sexual health, smoking cessation, substance misuse, consent and healthy relationships amongst others. There were appropriate responses

to mental health needs and access to specialist services to support positive mental health.

Inspectors found that young people were encouraged and facilitated to participate in age-appropriate leisure activities of their choice. At the time of inspection there was evidence that homecooked nutritious meals were prepared in consultation with young people. When a young person raised a complaint about food this was dealt with in a timely manner and there was evidence they were satisfied with the response. The supervising social worker communicated with the centre manager about this issue and was satisfied that there was an appropriate response from the centre.

The inspectors found that the toilet/bathroom facilities in the centre were not being used appropriately to accommodate the young people living in the centre. While one young person had ensuite facilities the other three young people shared one bathroom. There was a second toilet/bathroom facility on the ground floor however this was locked for staff use only. The records indicated that having access to one bathroom for three teenagers caused some friction at times in terms of accessing the bathroom when needed. The practice of locking the second bathroom facility must be reviewed by the manager and staff to facilitate its use by the young people. Additionally, the locking of the bathroom was not conducive to creating a homely environment for the young people.

There was a written medication policy and a comprehensive medical section held on each young person's file where all relevant information pertaining to health was recorded. There was a system in place for stock control and the safe disposal of medication. All medication was stored in a locked and secure location. Inspectors were informed that there were no medical errors since last inspection in June 2022 however, upon review of records found that three errors were referenced and responded to but not recorded in line with the organisational policy.

Compliance with Regulation	
Regulation met	**Regulation 10**
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 4.2**

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

Actions required:

- The registered provider must ensure that the policies relating to health and wellbeing are updated to be more holistic and include mental and sexual health.
- The registered provider must review the practice of locking the second bathroom facility to facilitate its use by the young people and to contribute to a homelike environment.
- The registered provider must ensure that all medical errors are recorded in line with organisational policy.

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 found that there was a clear reporting structure within the organisation with clearly defined roles and responsibilities. The centre manager was in post for four months at the time of inspection and had previously held the post of deputy manager.

Inspectors found that since the previous inspection in June 2022 there was a significant turnover of centre managers with three changes in the centre management. This impacted on both staff and young people and was not conducive to providing stable consistent leadership within the centre. Additionally, at the time of the inspection a recently appointed deputy manager was being relocated to another centre within the organisation and this move was imminent.

Staff information records evidenced a significant turnover of staff with five new social care workers commencing since January 2023. There was evidence that periodically the staffing numbers were not adequate to meet the needs of the young people and it was not possible to cover the required rota and ensure a third member of staff was rostered every day as required. This impacted on daily routines for young people and

staff alike. Young people chose not to meet with inspectors during the visit to the centre. Staff indicated that young people 'were understanding' around the issue of staffing. The young people's frustrations around staffing were not generally recorded as complaints however one complaint recorded about staffing was found to be upheld. There was also a period of high sick leave in June 2023 that resulted in staffing deficits. As a result, there was an expectation during this time that staff were moved between centres in order to fulfil the required rotas. Records reviewed during inspection indicated that this too impacted on staff morale.

At the time of inspection, the staff team comprised of the social care manager, deputy manager, three social care leaders and six social care workers. All were appropriately qualified in social care or held a relevant qualification. There were two dedicated relief staff who were appropriately qualified for the role. A review of a sample of personnel files evidenced up to date job descriptions and contracts on file for all positions. There was evidence that staff recruitment and retention was discussed regularly at senior management meetings.

Staff were provided with a comprehensive induction when they commenced employment. Revised and updated policies and procedures were communicated to staff and reviewed at team meetings. As highlighted earlier in this report this did not always result in adequate knowledge of legislation, policies and procedures. The systems in place to ensure staff have a good working knowledge of the centre's policies and procedures should be kept under review and monitored by managers.

Inspectors found that some practices in the centre were not in line with centre or organisational policies and where this occurred there was no evidence in the supervision records that these matters were addressed with the individual staff members to ensure accountability.

There was evidence that the social care manager encouraged staff to exercise professional judgement and collective responsibility and supported them to develop their decision-making skills. There was a system in place to have regular team meetings, attendance was good and there was a set agenda and review of previously agreed actions.

Notwithstanding this, inspectors found that there was a lack of evidence of collaborative team work to support child centred, effective care and support. Inspectors reviewed centre records and supervision records and found that since late 2022 there was evidence of a serious, negative and ongoing staff team dynamic.

There was evidence, corroborated by staff, that this had negatively impacted on young people who were aware of the team dynamics. Social workers for two young people informed inspectors they were also aware of this dynamic and one young person had brought the issue to their attention. Inspectors found that this issue also negatively impacted the staff team and contributed to low staff morale and staff retention. The external manager was aware of team dynamics and efforts were made to resolve the issues through team facilitation in January and March 2023. Despite some initial improvements in teamwork reported, the inspectors found that issues around the team dynamics remained a current and ongoing issue. While efforts were made by managers to explore team issues for each individual in supervision the manner in which it was explored was not found to be solution focused or effective to resolve the negative team dynamic. There were breaches of confidentiality which further undermined trust and created further tensions within the team. Inspectors found that there was a lack of evidence that aspects of poor practice by experienced members of the team was challenged appropriately and there was an understandable perception of different levels of accountability. This issue was transparently discussed at management meetings however actions and follow up was not evident to inspectors.

The was a comprehensive clear supervision policy, and records reviewed indicated that in more recent months supervision was taking place within the stated timeframes of four to six weeks. The centre manager and deputy manager provided supervision for the core staff team and social care leaders were approved to facilitate 'supplementary supervision' as and when required. There was a system in place to ensure that all staff received supervisee and/or supervisor training in line with standards and organisational policy. Inspectors found that there was a good link to training and professional development and placement planning. Despite the negative team dynamic, staff interviewed felt there was good support from internal and external managers and that supervision gave them an opportunity to reflect on their practice.

The inspectors found that the practice of supplementary supervision required further review. The manner in which it was implemented at the time of inspection, did not promote positive learning and development. There was evidence that it undermined confidence of some social care workers on the team. Inspectors found also that frequent changes in allocated supervisors was not conducive to implementing the supervision policy as intended. Every effort should be made to have consistent supervisor/supervisee relationships. The supervision records reviewed also

evidenced a lack of connection between one session and the next in terms of reviewing agreed actions.

The organisations' policy stated that the supervision process required monitoring and quality assurance arrangements to be in place. The regional manager had responsibility for regular oversight of supervision however due to competing demands on their time had not reviewed records since April 2023. The registered provider indicated that an annual supervision audit was carried out by the quality assurance team however no audits by the quality assurance team since the last inspection of this centre were available at the time of inspection.

Following a request by the inspection team, a review of the staffing dynamic to include analysis of supervision records, was carried out by the quality assurance department and a number of findings reflected deficits identified by the inspectors. The themes and sources of conflict and contributory factors were identified, and it was noted that no risk assessment relating to this issue took place. This report made findings in respect of increased supervision, recording of supervision, review of supervision records and a centre risk assessment. Inspectors concur that the team dynamic requires close monitoring to assess whether issues are being managed and resolved at team level to support the provision of child centred, safe and effective care and support.

There was an on-call policy in place dated June 2022 where staff could access out of hours support. In general, staff reported that this was supportive and worked well in practice. Inspectors found however that there were differing views on how promptly a designated on-call person would be expected to respond. Senior management confirmed that staff who are on-call are expected to answer the phone and respond immediately to the needs of the centre. The policy and procedure should be revisited to ensure clarity across the organisation. In one instance, calls for support were not responded to and inspectors were informed that this was addressed by the regional manager, however there was no record of this available to demonstrate good governance in respect of adherence to policies. Earlier

Despite the challenges relating to staffing the young people were making good progress at the time of the inspection and a young person recently admitted was settling in well. One social worker interviewed stated that recent concerns they raised with management were listened to and responded to.

Training requirements for the team was reviewed at management meetings and explored with staff during the supervision process. Scheduled dates of training were planned in advance.

There was a policy in place and probation reviews and annual performance appraisals were undertaken. Inspectors noted however, that some appraisals did not take place as people moved into new roles. Inspectors recommend that appraisals take place prior to taking up a new post within the organisation.

There was some evidence in senior management meetings of learning from internal audits. The regional manager provided feedback to the team following audits. There was good evidence of reflection with staff about the implementation of the model of care.

It is important to note that both the regional manager and their direct line manager (the registered proprietor) described regular supportive communication, however there was no evidence of any formal supervision or appraisal process for the regional manager. Inspectors could not determine how the issues highlighted in this report were discussed and managed between the parties.

There was a policy in place and an employee assistance programme to support staff if they were impacted by their work.

Supports to the staff team were identified as access to a health insurance programme, supervision and training. There was a staff engagement forum that a representative from each centre attended. Management had conducted a review and analysis of themes and patterns arising from exit interviews. These were discussed at a senior management meeting in April 2023. Staff retention ideas and staff appreciation measures were explored. Senior management indicated that the measures implemented were starting to contribute to better retention. Some staff indicated that pay scales contributed to them moving from the company. Management stated they monitored sector pay scales as part of their workforce planning.

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 minimise the practice of staff moving between centres.
- The registered provider must ensure that there is collaborative team working to support child centred effective care and support. The actions of the internal review should be implemented in full, and the team dynamic monitored closely by senior management.
- The registered provider must ensure the practice of supplementary supervision is reviewed to ensure that it promotes positive learning and development for staff.
- The registered provider must ensure that organisational policy in respect of monitoring and quality assurance of supervision is implemented in full.
- The registered provider must ensure that annual performance appraisals take place for all staff and are recorded on personnel files.
- The registered provider must ensure there is evidence that the regional manager receives formal supervision and appraisal in line with organisational policy and best practice.
- The registered provider must ensure that there is evidence of quality assurance by the dedicated department in operation in line with organisation policies.

4. Corrective Actions and Preventive Actions (CAPA)

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure the child safeguarding statement and the safeguarding and child protection policy is updated as a matter of priority and satisfy themselves that all staff understand and implement these correctly in practice. Staff must be familiar with the risk assessment on the CSS.	The CSS was reviewed at the Team Meeting on 26.10.23 and will be reviewed through supervision to ensure the team are familiar with its contents. The safeguarding statement will be updated with the addition of CSE by 03/11/23 and will be discussed at the next team meeting 09/11/23. The team have completed the Tusla's child sexual exploitation procedure training in September 2023 and CSE will be incorporated into all child protection courses moving forward.	Policy review will continue to be documented by centre management in team meeting minutes. A senior management child protection themed audit, inclusive of staff interviews, will be completed by regional manager in November 2023 and actions required shared with the team. A list of responsibilities for all social care grades with regard to child protection has been generated and shared with all teams on 27.10.23.
	The registered provider must ensure that there is absolute clarity on who holds the role and responsibility of designated liaison person.	DLP training is being developed for all centre and deputy managers and will be rolled out 27/11/23. A list of roles and responsibilities regarding safeguarding is being developed and will be communicated with all staff on	Staff's knowledge on the role and responsibility of the designated liaison person will be tested in upcoming child protection audit November 2023. Child protection policy will be reviewed at team meetings during the course of the year.

		27/11/23. This will be discussed in team meetings and supervisions, alongside the child protection policy to ensure that all staff are clear about their responsibilities and the responsibilities of the DLP. The child safeguarding statement was reviewed in team meeting 26/10/2023.	Issues arising in respect of safeguarding practice will be addressed with staff during team meetings and formal supervision.
	The registered provider must update the ensure that staff undertake the Tusla e-Learning training on the role of mandated persons in line with the organisations' safeguarding policy. They must update the policy to include the Tusla national policy and reporting procedure in respect of child sexual exploitation and ensure staff undertake this training.	All staff have completed Tusla e-Learning training re: the role of a mandated person. Child sexual exploitation procedure training was completed by the team in September 2023. The policy was updated to include CSE and discussed with the team in team meeting 13/09/23. Tusla's child sexual exploitation procedure will be discussed at team meeting with all staff on 09/11/23.	Policy review will continue to be documented by the centre management team when discussed with the team in team meetings. Team meeting minutes are reviewed by the compliance officer to ensure policies are reviewed as required.
	The registered provider must ensure that where specific vulnerabilities are identified for young people that a robust and co-ordinated response is implemented. Specific safety plans must be devised and reviewed, and the	A full review of young people's risk assessments and safety plans is to occur by the 30.10.2023 by centre management, with all risk assessments fully reviewed to ascertain the robustness of the risk management plan and to encapsulate the	Regional manager will review risk assessments and safety plans in place in December 2023 and record their findings in monthly governance report with actions required shared with the team and recorded in the team meeting minutes.

	direction of social workers followed to ensure appropriate safeguards are implemented.	identified vulnerabilities for all residents. All risk assessments will be reviewed, updated as required with appropriate consultation with social work departments. Management presence will be in place at daily handover to ensure that risk management and safety plans are fully understood by the oncoming team. Risk management and safety plans will be fully reviewed at team meetings,	
	The registered provider must ensure that all vetting procedures are in line with organisational policy and safe vetting practices.	A review of all personnel files will be completed by centre management by 24/10/2023, inclusive of staff vetting. The discrepancy in references has been addressed and is in line with organisational selection criteria.	All files for new staff who are onboardings will be reviewed by centre management to ensure that vetting processes are in line with organisational policies. A personnel file audit will be completed by senior management in 2024.
	The registered provider must ensure that staff are fully familiar with the whistleblowing policy and their obligations to report poor practice.	Centre management reviewed the centre protected disclosure/whistleblowing policy with the staff team on 26/10/2023 at a Team Meeting.	Regional manager will be completing a child protection audit in November 2023 and staff interviews will include their familiarity with the protected disclosures policy.
	The registered provider must ensure	Centre Management will continue to	Regional manager will review any incidents

	there is evidence of accountability where policies and procedures have not been implemented.	communicate any issues regarding staff's adherence to policies and procedures to regional manager and this will be reviewed, and action taken, in line with company policy in respect of accountability.	of staff not adhering to policies and procedures within supervision with the centre manager or centre management meetings and ensure that an action plan is implemented which demonstrates accountability of the staff member.
4	The registered provider must ensure that the policies relating to health and wellbeing are updated to be more holistic and include mental and sexual health.	The registered provider will review the general physical health policy to incorporate the areas of mental and sexual health by 17/11/23. The updated policy will be circulated to all centres for review at their team meetings.	The registered provider will continue to review policies and to circulate updated policies and procedures for discussion at team meetings. Team meeting minutes are reviewed by the compliance officer to ensure policies are reviewed as required.
	The registered provider must review the practice of locking the second bathroom facility to facilitate its use by the young people and to contribute to a homelike environment.	The second bathroom will remain open for use by both the staff team and young people from 20/10/2023.	Regional manager will ensure that the second bathroom is not locked during their visits to the centre and document same in their monthly monitoring report.
	The registered provider must ensure that all medical errors are recorded in line with organisational policy.	A full review of medication records was completed by centre management team on 27/10/2023. The medication policy will be brought to the team meeting on the	Regional manager will complete a medication audit in February 2024 and ensure that if any medical errors have occurred that they have been recorded and

		09/11/2023. All medical errors will be recorded in line with organisational policy by the centre manager.	responded to in line with organisational policy.
6	The registered provider must minimise the practice of staff moving between centres.	Staffing deficits are not a current concern. Current staffing levels are 1 SCM, 1 DSCM, 3 SCL, 7 SCW and 2 RSCW. Staff moving to different centres will only occur where there are emergency situations. Staff may also be moved temporarily in response to risk management plans.	Regional manager will review rosters and liaise with centre managers regionally to ensure that the practice of moving staff between centres is minimised and associated risk management plans are reviewed with regularity.
	The registered provider must ensure that there is collaborative team working to support child centred effective care and support. The actions of the internal review should be implemented in full, and the team dynamic monitored closely by senior management.	The quality assurance manager completed a full review on team dynamics on 08/09/2023. This report was reviewed by the centre management team and regional manager in the centre's management meeting on 26/10/23 and an action plan developed and implemented.	Team dynamics will be closely monitored by the regional manager during weekly site visits and observations recorded in monthly monitoring report. Group dynamics will be discussed and recorded each month in the centre manager's supervision, along with action plans identified, ensuring they are enacted.
	The registered provider must ensure the practice of supplementary supervision is reviewed to ensure that it	Practice of supplementary supervision was reviewed in the centre's management meeting 26/10/23 to ensure that it is	A supervision audit will be completed by regional manager in January 2024 which will include a review the use of

	promotes positive learning and development for staff.	positive and promotes development of staff. Supplementary supervision will only be completed by centre manager or deputy manager moving forward.	supplementary supervisions and feedback will be provided to the centre management team.
	The registered provider must ensure that organisational policy in respect of monitoring and quality assurance of supervision is implemented in full.	A review of all centre supervisions, both quantitatively and qualitatively will be completed by regional manager January 2024. All findings will be provided to centre management team. This supervision audit will be repeated in the second half of 2024 to ensure actions and learning have been applied.	Supervision audits will be completed by regional manager and feedback/ action plans provided to the centre management team.
	The registered provider must ensure that annual performance appraisals take place for all staff and are recorded on personnel files.	A review of staff appraisals was completed by the centre management team on 20.10.2023 and found that all staff have up-to-date appraisals on file as required.	Centre management team will ensure that staff appraisals are scheduled and occur as required and that the associated records are filed.
	The registered provider must ensure there is evidence that the regional manager receives formal supervision and appraisal in line with organisational policy and best practice.	The registered provider will keep a record to evidence formal supervision that the regional manager receives. The registered provider will also schedule annual appraisals for the regional manager.	The registered provider will ensure there is evidence that the regional manager receives formal supervision and appraisal.

	The registered provider must ensure that there is evidence of quality assurance by the dedicated department in operation in line with organisation policies.	External auditing will continue to be carried out by the Regional Manager who is external to the centre. Evidence of quality assurance by the dedicated department is demonstrated through the provision of centre monthly reports, review and oversight of Senior Management themed audits. The compliance officer will continue to ensure that learning from other inspection reports nationally is demonstrated through monthly review of centre documentation and reports e.g. young people being consulted in respect of placement plan review, discussion at Team Meetings where policies and/or procedures have changed. The Quality Assurance Manager and Director of Services will continue to review external feedback, organisational learning and implementation of action plans e.g. quarterly meetings to review learning from inspections. The quality assurance team will review its	The registered provider will continue to review the roles and responsibilities of the department to ensure that it is providing quality assurance in line with organisational policy.

		current recording systems to ensure that there is evidence available to support these activities and to demonstrate scheduling, oversight and direction, and ensure that this revision is in place in January 2024. A schedule for auditing for 2024 will also be developed by the Quality Assurance department and will be effective January 2024.	