An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 141

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Brighter Futures for Children**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**10th and 11th January 2023**
Registration Status:	**Registered from 08th August 2021 to 08th August 2024**
Inspection Team:	**Linda McGuinness** **Anne Mc Evoy**
Date Report Issued:	**17th April 2023**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 08th August 2018. At the time of this inspection the centre was in its second registration and was in year two of the cycle. The centre was registered without an attached condition from the 08th August 2021 to the 08th August 2024.

The centre was registered to provide medium term multi-occupancy placements, for up to two young people, male and female, aged thirteen to seventeen years on admission. Due to specific needs of the young person in residence it was agreed that the centre would remain single occupancy at this time. The model of care was based on attachment and resilience theories and an understanding of the impact of trauma on child development. The centre's stated objectives were to provide a safe and structured residential environment with a high level of support in line with *The Three Pillars Model of Care (Three Pillars of Transforming Care, Bath and Seita, 2018)*. The model was based on three key elements: safety; connections and coping. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.1
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 person, 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 to the relevant social work departments on the 3rd February 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 22nd February 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: 141 without attached conditions from the 08th August 2021 to the 08th August 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

Inspectors found from speaking with the young person, reviewing centre records and through inspection interviews that a child-centred approach was well established in the centre and the young person was at the centre of planning, decision making and day to day care. From a review of records inspectors could see that the reasons for decisions made were explained to the young person in line with their age and level of understanding. The young person also completed an inspection questionnaire providing positive feedback on all aspects of their care.

There was an established culture where the young person was encouraged to participate and express their views. The centre had policies relating to consultation with young people, children's rights and complaints and in general, there was evidence that these were implemented in practice. While the complaints policy and procedure was consistent with legislation, regulations, and best practice, inspectors found that the team required further clarity in respect of determining the difference between minor and major complaints. This was under discussion and review at the time of inspection as the social work department had also give feedback in respect of this issue.

The staff team demonstrated that they were attuned to the needs of the young person and it was evident that they were actively involved in their daily and weekly plans and activity programmes. The young person confirmed when talking to inspectors that they felt listened to and liked living in the centre. They were aware of the complaints process and confirmed that it was explained to them regularly if they said they were unhappy about anything. The young person named several members of the staff and management team that they would talk to if they were displeased with any aspect of their care. They were also aware of the role their key worker, social worker, guardian ad litem, and the advocacy group Empowering People in Care (EPIC).
Inspectors noted significant improvements in how the young person was able to communicate and express themselves as they had met them during two previous

inspections of this service. During the onsite visit to the centre inspectors observed warm and caring interactions between the staff team and the young person.

The young person's social worker was interviewed by inspectors and stated that they were very satisfied with the placement and that the young person continued to make significant progress. They commended the work of the internal management team who listened to the young person and advocated strongly for them in every aspect of their care. The allocated social worker was confident that the young person was at the centre of decisions, was aware how to complain and that any issues they had were taken seriously.

Inspectors found that complaints were appropriately recorded and responded to by team members and centre management with evidence of oversight at senior management meetings. Inspectors could see discussions about identifying areas of improvement/learning from the review of complaints. Further, there was evidence that practice improvements were implemented as a result of this analysis.

While documentation relating to complaints and their resolution was held in centre records, the outcome of individual complaints was not recorded clearly on the young person's file as required.

Inspectors found evidence that the young person had opportunities to provide feedback relating to the complaints process and it was clear that management and team placed the young person at the centre of decisions. The manager met with the young person at regular intervals at their request and actively listened to their experience of living in the centre from their perspective.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **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 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required.

- The centre manager must ensure that there is clarity relating to the thresholds distinguishing minor and major complaints.
- The centre manager must ensure that the outcome of complaints is clearly documents on the young person's record.

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.

Inspectors found that there were policies, procedures and systems in place to safeguard and protect children from abuse and neglect. The centre's suite of policies was updated in March 2022. However, inspectors noted that one aspect of the safeguarding policy was not in line with Children First: National Guidance for the Protection and Welfare of Children, 2017. Staff interviewed during the inspection process were aware of their statutory obligations as mandated persons. However, there was some confusion relating to the role of the Designated Liaison Person (DLP). Management and staff provided differing accounts in interview as to the role of the DLP. Some provided information stating that it was the responsibility of the DLP to report a child protection or welfare referral to Tusla. When this was explored, inspectors found that the confusion stemmed from a DLP training programme that was sourced externally and this training had provided inaccurate information that was not congruent with Children First: National Guidance for the Protection and Welfare of Children, 2017 and The Children First Act, 2015. There was also confusion relating to a post of designated liaison officer which also stemmed from the same training. The centre manager accepted this and took immediate action to ensure clarity.

A child safeguarding statement was displayed in the centre and was deemed compliant by the Tusla Child Safeguarding Statement Compliance Unit. This statement contained some risks which were not relevant to safeguarding such as attendance in education and should be removed to ensure clarity. The centre manager maintained a list of mandated persons within the centre.

All social care staff had completed Tusla's Children First e-learning training programme and also received additional training in the organisation's child protection policies and procedures. Despite this training the confusion outlined above remained. Inspectors recommend that staff complete the available online training for mandated persons. There was evidence that policies were discussed and refreshed at team meetings.

There was a child protection and welfare register in place to record and track any child protection and welfare referral notifications. A review of care files and centre records showed that there was regular communication with the supervising social work department on the status of open child protection referral notifications. One notification remained open at the time of inspection. Centre management received notification from the social work department following this inspection that a meeting was planned with An Garda Síochána to conclude and close out this process.

There was a policy and procedure in place to manage any allegation of harm by a staff member. There was one such incident in 2022 and the centre response was fully in line with the process set out in policy. Records showed the centre manager maintained good oversight of the register and reported delays or issues arising to senior management.

In interview, staff were clear about their responsibility to report poor practice and described the procedures they would take if such a situation occurred. They were confident they could speak up and that internal and external management would listen and respond appropriately. Inspectors found that this was evident in practice in the centre whereby managers were open to receiving feedback from the team and had taken prompt and appropriate action to address issues brought to their attention. Notwithstanding this, inspectors found that the whistleblowing/protected disclosures policy did not sit within the main policy document and was not aligned to safeguarding and child protection. While it set out the organisation's responsibilities under the Protected Disclosures Act, 2014 there was no connection to the code of conduct, safeguarding or reporting poor practice by a colleague. Despite evidence of good practice in the centre relating to reporting and managing incidents or issues, management and staff interviewed during inspection were not fully aware of the policy.

The centre had a bullying policy that and described all types of bullying including physical aggression, intimidation and cyber bullying. This set out procedures to follow for both young people who were victims or perpetrators of bullying. The policy

was linked to the model of care and set out the expectation to provide a safe environment to prevent any occurrence of bullying. The policy, however, was not entirely in line with Children First, 2017 as it did not set out the requirement to notify serious bullying to Tusla, Child and Family Agency. As this young person did not live with other young people, there was no peer bullying and the team were alert to issues of bullying in community settings.

There was evidence of a partnership approach between the centre, the social worker and the young person's Guardian ad Litem to promote the young person's safety and wellbeing. The young person confirmed to inspectors they had people they could speak to if they felt unsafe.

During interviews staff demonstrated a keen awareness of the young person's needs and vulnerabilities. These were identified through various planning documents and key working and other measures were put in place and to respond in a proactive way. It was evident that the young person was making positive progress. Where key working was planned and did not take place it was evident that this was followed up promptly by management who held staff accountable for their work. Significant events were reviewed for learning purposes and a culture of reflective practice was evident with a willingness to alter practice to better meet the needs of the young person. However, in one instance this was not followed though as intended and is further discussed under standard 6.3 of this report.

Overall, it was the findings of inspectors that the young person was provided with safe care and support and that they were safeguarded from abuse and neglect.

Compliance with regulations	
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 that the role of the DLP is set out accurately in policy and that all staff are clear about the correct reporting mechanisms.
- The registered provider must ensure that any training sourced or provided is fully in line with Children First: National Guidance for the Protection and Welfare of Children, 2017
- The registered provider must ensure that the bullying policy is updated to include referral to Tusla for serious bullying.
- The registered provider must ensure that all the whistleblowing/protected disclosures policy is aligned to safeguarding and the purpose of the centre and that all staff are fully familiar with it.

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 from interviews with staff in the centre that they understood their individual roles and responsibilities. There were clearly defined governance arrangements and structures that set out the lines of authority and accountability. However, upon review of the policy document, inspectors found that it contained reference to the roles and responsibilities of a quality assurance and practice manager, a role which was no longer in place. As mentioned above, there were some aspects of the company's policies that required review and a follow up process to ensure all staff were fully aware of the policies and procedures to be followed.

From review of management meetings, supervision and other centre documents, inspectors found that practice enhancement sessions were provided to staff who required further development. However, a process of benchmarking the responsibilities of their job description against their practice was not evident. Inspectors did not find that there were robust and timely responses to assess staff practice against the all the responsibilities set out in the job description. Where a staff member had designated responsibilities there must be evidence that they were supported and challenged to perform that role to the best of their ability and that appropriate action was taken if timely improvements are not forthcoming.

Inspectors found that the centre provided a child-centred, safe and effective service and that staff in the centre were supported to use professional judgment. The management team had established a culture whereby staff members were confident to challenge the practice of others if concerns arose and from review of centre records and inspection interviews this was evident in practice.

Inspectors found that there were procedures in place to protect staff and minimise any risk to their safety. Risk assessments and safety plans were implemented if issues were identified.

Staff meetings took place every fortnight for four hours and were a mixture of online and in person meetings. These meetings also included review of policies and some training to staff or guidance from specialist consultants to support the care of the young person. Staff confirmed in interview that there was generally a good team dynamic and that good communication was key to delivering consistent care. If practice concerns arose there was trust in centre management to address and resolve the issue. Social workers who provided feedback to inspectors commented positively that management both supported and challenged the team in their day to day practice and that incidents were reviewed for learning purposes.

A review of the minutes of management meetings evidenced a culture of reflective practice and review of incidents to inform service improvements. Inspectors noted however that repeated issues were arising over several meetings with no evidence that the issues were progressed or closed out. Centre management must ensure that decisions made, and actions required are appropriately followed up.

Inspectors found that from a review of an incident in June 2022 that learning was taken and practice changes were implemented in terms of staff rostering arrangements. It was determined that staff should not spend long hours in the centre and should have adequate breaks to mitigate against stress affecting their practice. However, inspectors reviewed the rotas since June 2022 and found that on 32 occasions staff members completed an overnight shift and worked on to complete a day shift. Also, on four occasions staff members completed double overnight shifts. This was not best practice and no risk assessments were completed to inform this decision. Inspectors found that staff who required practice enhancement programmes had completed many double shifts. These practices were not in line with best practice and were inconsistent with the organisations' own findings upon review of the incident.

There was a focus on professional development. Inspectors reviewed training records and found that staff were supported and encouraged to develop their skills and that this was aligned to the needs of the young person. It was not possible for inspectors to determine however if training in the model of behaviour management was in line with the required timeframes as all certificates were not held on the files reviewed. A recent audit in the centre prior to inspection identified some training deficits and a training schedule was immediately implemented to address this as a matter of priority.
Senior management meetings showed that there was shared learning between the organisations two centres and that the findings of inspections were used to inform organisational service improvements. The registered provider attended these meetings and challenged centre management in a supportive way if required.

There was a supervision policy in place and all staff received regular supervision from the centre manager who was appropriately qualified and trained to do so. Inspectors recommend that management provide a briefing to the team about the functions of supervision and how to make best use of the process. While roles and responsibilities were discussed at team leader meetings, inspectors found that the records of individual supervision could be improved. Where staff have specified roles then this must be discussed as part of supervision to ensure that there is accountability.

Records of supervision were maintained however a technical issue meant there was a backlog in both parties signing the records to indicate agreement with the discussion and decisions. This is important especially where there are professional development plans in place and staff members are assigned tasks or have to reflect to take steps to improve their practice.

There was evidence that following a period of probation that appraisals of staff practice took place on an annual basis and records were available for review.

There were mechanisms in place to support staff who suffered stress or injury in the course of their work and this was guided by policy. These supports included debriefing, critical incident reviews, planned and responsive supervision, and an employee assistance programme. Free professional online or in person counselling and external consultancy to reflect on the model of care and model of behaviour was available as well as group supervision to address possible vicarious trauma associated with working in residential care.

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

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

Actions required.

- The registered provider must ensure that the organisation's policy document accurately sets out individual roles and responsibilities and removes reference to roles no longer relevant.
- The registered provider must ensure that decisions and actions required from management meetings are appropriately followed up and recorded.
- The centre manager must ensure that all training certificates are held on staff files to evidence compliance with the requirements for regular refresher training.
- Where a staff member is unqualified. the registered provider must ensure that evidence of progression towards qualification is provided to the alternative care inspection and monitoring service.
- The centre manager must ensure that supervision records contain evidence of discussions about accountability for all aspects of specified roles.
- The registered provider must ensure that staffing practices in the centre are reviewed and brought into line with best practice and that the organisations findings are fully implemented with staff not working double shifts.

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4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure that there is clarity relating to the thresholds distinguishing minor and major complaints.	All complaints to be discussed in team meetings – all parties explore and agree if it is a minor or major complaint. Policy updates due by 31/03/23. Will remove examples provided within the complaint policy and note that all complaints must be considered and discussed with management in terms of minor and major status, these will then be discussed within meetings to ensure all staff agree with status or explore and escalate/demote as appropriate.	Centre policy will be clear on the procedure to determine complaint classification and will be followed by all staff and management. All new policies will be provided to the team when available and these will be explored during team meetings with staff.
	The centre manager must ensure that the outcome of complaints is clearly documented on the young person's record.	A duplicate of the complaint register was added to the YP Care File on the 17.01.23. This means that the process and the outcome of all complaints is clearly recorded in the young person's file. Photocopies of the Complaint Register that noted all YP previous complaints was	Centre policy will be clear that all complaints made will be noted in both the YP Care File and with the house complaint register. All new policies will be provided to the team when available and these will be explored during team meetings with staff.

		added to the YP file also.	
3	The registered provider must ensure that the role of the DLP is set out accurately in policy and that all staff are clear about the correct reporting mechanisms.	The registered provider has amended the policy to set out accurately the role of the DLP and clarified for staff the correct reporting protocol.	This measure will ensure all staff have been trained with the correct information and will understand their role as mandated persons and Designated Liaison Persons.
	The registered provider must ensure that any training sourced or provided is fully in line with Children First: National Guidance for the Protection and Welfare of Children, 2017	Management have been advised all staff must complete the Tusla 'Children First E-Learning Programme. Staff will also cover the Tusla 'Children First E-Learning programme during a Team Meeting.	As above
	The registered provider must ensure that the bullying policy is updated to include referral to Tusla for serious bullying.	The bullying policy has been amended and now reads: "If an incident or pattern of bullying is assessed as meeting the threshold, the Social Care Worker, as a Mandated Person, must submit a Child Welfare & Protection Report Form (CWPRF) through the Tusla Web Portal." The Social Care Worker may consult with the Social Work Department and/or the DLP, but this is not a requirement."	The amendment to the policy document will be circulated to all staff to ensure they are all aware of the protocol.

	The registered provider must ensure that the whistleblowing/protected disclosures policy is aligned to safeguarding and the purpose of the centre and that all staff are fully familiar with it.	The whistleblowing policy has been incorporated into the main policy documents folder and staff will be made aware that the whistleblowing policy can be used as part of safeguarding to promote the welfare of and protect the young people whilst also protecting the staff member disclosing information through the policy.	Staff will be advised during team meetings and during the induction process how the whistleblowing policy can be used as part of safeguarding to promote the welfare of and protect young people.
6	The registered provider must ensure that the organisation's policy document accurately sets out individual roles and responsibilities and removes reference to roles no longer relevant. The registered provider must ensure that decisions and actions required from management meetings are appropriately followed up and recorded. The centre manager must ensure that all training certificates are held on staff files to evidence compliance with the	The registered provider has amended the policy documents to clarify the existing staffing roles and responsibilities and removed references to posts that are no longer relevant. Managers will be required to produce action lists after each management meeting clarifying the person responsible with a time scale. Managers will be required to send the completed action list to the Director on a weekly basis. The historical training certificates that were removed from the staff files on the advice of the previous governance	The requirement for a revision/amendment of the policy documents will be included as a standing item on the agenda for senior management meetings. Action plans will be followed and tracked during management Meetings. Senior management has been made aware that all mandatory training certificates are to be retained within staff files and cannot

	requirements for regular refresher training.	manager, are currently being sourced from trainers and will be added to the file when obtained.	be removed. All mandatory training certificates are required to evidence continued training from the commencement of employment. A staff file guidance document will be developed by the 28/02/23. House managers will be aware of staff files layout and procedures through this guidance document.
	Where a staff member is unqualified. the registered provider must ensure that evidence of progression towards qualification is provided to the alternative care inspection and monitoring service.	Managers are required to ensure staff who need to progress their qualifications, produce credible written evidence during each supervision session to prove they are maintaining their registration with the educational establishment and are on track to complete the required qualification within the agreed timescale.	The procedure for the staff member to provide written evidence from the educational establishment will form part of a contract between the staff member and the company before the course begins. The house manager will be required to produce this evidence at senior management meetings.
	The centre manager must ensure that supervision records contain evidence of discussions about accountability for all aspects of specified roles.	Managers will ensure a copy of the job descriptions are circulated to all staff ahead of supervision sessions for the staff members to read. During supervision the managers will enquire whether the staff members understand their individual	House managers will be expected to raise any concerns about staff member's practice to the Director, at the earliest opportunity, and bring the issues to the senior management meetings for discussion.

		accountability for all roles. As it will not be possible for managers to discuss all aspect of the specified roles, Managers will select specific roles for in-depth discussion during supervision to ensure the staff member has the required competence to carry out their role satisfactorily.	
	The registered provider must ensure that staffing practices in the centre are reviewed and brought into line with best practice and that the organisations findings are fully implemented with staff not working double shifts.	The proprietor has advised house managers that staff are not permitted to work double shifts and/or an extra day shift following a night shift. The reasons for staff completing additional shifts was to accommodate the young person's holidays and to cope with staff absences due to Covid infections. House managers will complete a risk management strategy by 28/03/2023 to cover emergencies that may arise in the future.	Job advertisements to attract additional relief social care workers are ongoing. This will remove the need for any permanent staff member to complete double shifts.