An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 024**

**Year: 2024**

# Inspection Report

| | |
|---|---|
| **Year:** | **2024** |
| **Name of Organisation:** | **The Cottage Homes Child and Family Services** |
| **Registered Capacity:** | **Four Young People** |
| **Type of Inspection:** | **CAPA Review** |
| **Date of inspection:** | **9th, 10th & 11th September 2024** |
| **Registration Status:** | **Registered from the 31st October 2024 to the 31st October 2027** |
| **Inspection Team:** | **Anne McEvoy** |
| **Date Report Issued:** | **10th December 2024** |



TUSLA An Ghníomhaireacht um Leanaí agus an Teaghlach Child and Family Agency

# 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 a corrective actions and preventative actions (CAPA) review 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 2009. At the time of this CAPA review the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from the 31st October 2021 to the 31st October 2024.

The centre was registered as a multi occupancy service to provide care to four young people from age thirteen and seventeen on admission. The model of care was described as relationship based. There were three young people living in the centre at the time of the inspection.

## 1.2 Methodology

The inspector examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated 6th, 7th and 8th March 2023. The inspector reviewed documentation provided by the centre via email in response to required evidence of CAPA implementation. Additionally, the inspector interviewed the centre manager and one social care staff to further triangulate the evidence provided.

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 18th September 2024. The findings of the CAPA review was used to inform the registration decision.

The findings of this CAPA review has determined the centre to have fully implemented the required actions and therefore 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: 024 without attached conditions from the 31st October 2024 to the 31st October 2027 pursuant to Part VIII, and 1991 Child Care Act.

## 3. Inspection Findings

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

**Theme 5: Leadership, Governance and Management**

**Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.**

**Issue Requiring Action:**

- The registered provider must review the risk management framework and ensure that all risks are appropriately categorized, recorded and appropriate safety plans are in place.
- The centre manager must ensure that all care directions/safety plans are recorded within young people's files.
- The registered provider must ensure that all staff are trained in the use of the risk management framework.
- The centre must ensure that all restrictive practices within the centre have associated risk assessments in place in line with the centre's policy, and that these practices remain in place for the shortest time possible and are reviewed regularly.
- The registered provider must ensure that all staff are trained in the new policies and procedures.
- The registered provider must review the significant event review system to ensure it is effective in practice and allows for oversight of trends and patterns within the centre.
- The centre manager must ensure that learning from significant event reviews is shared with the staff team to promote the development of best practice.
- The centre manager must ensure that supervision of staff occurs in line with policy.
- The registered provider must ensure that audits completed, and action plans put in place include all identified actions and are reviewed and tracked to ensure completion of actions. This needs to be demonstrated across centre records.

**Corrective Actions:**

- Management with managers and director have reviewed the risk management framework, are in the process of drawing up guidance document for staff and plan a training day for staff members in relation to the risk management framework.
- The safety plan template has been introduced to the staff team and currently is in place where necessary for young people.
- Staff training planned for 20th June on the risk management framework.
- Risk assessments have been drawn up for all restrictive practices. Risk assessments have been added to young people's risk register. Continue to review restrictive practices weekly at team meetings.
- Ongoing roll out of policies and review at team meetings in line with schedule.
- Review of the purpose and scope of the internal SEN review group to take place on the 22nd of May by the director and managers.
- Learning from SEN reviews occurs at the team meetings in the two weeks following the SEN review group.
- At the beginning of each month the manager checks supervision dates to ensure they are scheduled. Supervision to occur every 4-6 weeks.
- The manager will provide an update on progress made in relation to action plans and the director will track process through the centre records. New form drawn up to collate all actions from audits.

**Review Findings:**

The inspector reviewed the minutes from a risk management subgroup committee. The first meeting was attended by the director of services and the chairperson of the board of management. It evidenced the review of the risk management framework and formalised the notification procedure for centre managers to notify senior management of high-level risks within the organisation. This included being notified when a risk moved from red to amber or from amber to red as part of their risk matrix. Further meetings of the sub-group were attended by the centre managers of each centre within the organisation. The centre held a risk catalogue identifying all open and closed risks on it. The risk catalogue was reviewed at the start of each senior management meeting sampled by the inspector. A review of documents submitted to the inspector evidenced that risks are discussed at weekly team meetings, and they were discussed at case management meetings for each young person, held every four to six weeks. The inspector found that the minutes recorded of these discussions were robust and informative.

Audits conducted by the director of services reviewed the categorisation and recording of risks and appropriately identified any actions that were required. There was good evidence to support that this action was implemented.

The centre introduced a new safety plan document as part of the corrective actions from the last inspection. The inspector reviewed young people's care files where safety plans were required and found these to be comprehensive. There was evidence that these plans were drawn up in consultation with the allocated social work team and discussed in multi-disciplinary meetings with relevant professionals. The inspector found that one safety plan had a review date noted as "ongoing" and recommends that identified review dates be noted on safety plans to ensure that they are reviewed in a timely manner.

The inspector reviewed the training records for care staff members and found that training was provided to care staff on the risk management framework since the last inspection of March 2023. This was confirmed in interview with the centre manager and with a care staff member. Additionally, the training on risk management was added to the checklist for each new member of staff as they were inducted into the centre.

The inspector reviewed the restrictive practices in use within the centre and found that there were relevant risk assessments in place for each restrictive practice. Team meeting records reviewed noted that the centre discussed any new restrictive practices at the weekly team meeting and there was a system whereby continuing restrictive practices were reviewed every ten weeks. The inspector was advised by the centre manager in interview that this was a recording error and all restrictive practices, both new and recurring, were discussed at each meeting. There was evidence that risk ratings were reviewed and increased or decreased in line with the presenting behaviours of young people at the time of review. The centre differentiated between centre restrictive practices such as knives being kept in a locked press and individual restrictive practices, such as room searches. A review of the risk assessments detailing that knives be kept locked away did not sufficiently evidence the rationale for the continuing restrictive practice. The inspector recommends that all restrictive practices be reviewed as individual restrictive practices individual to each young person. Each restrictive practice needs to identify the risks presenting to the safety and welfare of each young person and the risk assessment amended as required.

The inspector was advised that most centre policies were now reviewed. This review was undertaken by the director of services and a policy roll out sheet was sent to the inspector to evidence the date that the policy was enacted. In interview, the care staff member stated that policies were discussed in team meetings and care staff were asked questions to evidence their understanding of the new policies. The inspector was provided with a sign off sheet for one care staff member and this was signed by the staff member when the policy was read. The inspector recommends that to further enhance this procedure a date is also added to the policy sign off sheet to evidence when the care staff read the policy. The centre manager advised that the director of services was further moving the policy review forward by combining relevant policies into thematic booklets based on the themes within the National Standards for Children's Residential Centres (2018) HIQA. This process was underway and theme one was completed.

The inspector reviewed a sample of centre management and senior management meeting minutes and found that there was robust discussion around the occurrence of significant events. The organisation conducted a review of the purpose and function of the SERG (significant event review group) and a clear plan was developed outlining what the SERG was to focus on. The inspector found that while oversight of recording remained, the review primarily focused on interventions and how the situation was responded to by the team. These meeting minutes also evidenced analysis of potential patterns and trends, and this was further demonstrated in the audits conducted by the director of services.

In interview, social care staff discussed their involvement with the SERG and the manner in which learning was recorded and relayed to the full care team. A representative from the care staff in the centre attended the SERG and participated in the discussion. A learning log was established from the meeting and this log was discussed at team meetings. The inspector found that minutes from the team meetings, sampled and reviewed, evidenced this action.

The inspector reviewed a sample of supervision dates on staff personnel files and found that in a nine-month period from January 2024 to September 2024, there were six supervision sessions held. This was in line with the centre policy on the frequency of staff supervision. Where supervision was required to be postponed due to meetings for young people or illness from staff, these supervision sessions were rescheduled to a new date within a week of the original date. This was confirmed in interview with a care staff member. At the end of each supervision session, the date for the next

meeting was decided and recorded. The centre manager confirmed that they check that all supervision sessions were scheduled as part of their governance.

A sample of audits was provided to the inspector for review. Each audit was accompanied by an action plan which identified all deficits noted in the audit and required interventions. The inspector found that the centre management responded in a timely manner to all identified actions. There was evidence of the director of services requesting, and being provided with, updates on the corrective actions, not only through audit action plans but also through participation at care staff team meetings and review of centre documents. Overall, the inspector found that the actions required under this standard were implemented.

| **Compliance with Regulations** | |
|---|---|
| **Regulation met** | **Regulation 5**<br>**Regulation 6** |
| **Regulation not met** | **None identified** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **Standard 5.2** |
| **Practices met the required standard in some respects only** | **Not all standards under this theme were assessed** |
| **Practices did not meet the required standard** | **Not all standards under this theme were assessed** |

## Regulation 7: Staffing

## Theme 6: Responsive Workforce

**Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.**

**Issue Requiring Action:**

- The registered provider must continue to actively recruit an additional staff member to ensure that the centre has sufficient staff in place to provide consistency in care to the young people.
- The registered provider must ensure that the changes made to the on-call policy and procedures are effectively brought into practice within the centre and that all staff are trained in the amended policy.

**Corrective Actions:**

- Ongoing recruitment in process in place. Engaged with agencies to source suitably qualified staff. Incentives in place for staff to recruit new staff members. Reviewed criteria for applicants to broaden the scope.
- We are reviewing how the on-call system is utilised to ensure we get the best from the system with the least amount of impact on the management team who are not renumerated for this task.

**Review Findings:**

The inspector found that the staffing complement in the centre was sufficient to meet the needs and complex behaviours of the current cohort of young people. The centre had one centre manager, one deputy manager, four social care leaders, six social care workers and one job share red circled social care leader. There were extensive years of experience between the centre management with the centre manager having worked in the centre for 19 years and the deputy manager having worked there for 23 years. Only three of the care team members were appointed since the time of the last inspection, with all others being at least two years in the centre. The centre had access to seven relief staff members, six of whom were appointed since the last inspection. The inspector found that care staff were advised of incentives to "refer a friend" for potential employment within the centre. In interview, the inspector was advised that the centre had engaged with a selection of-recruitment agencies in an

effort to consistently source qualified and suitable staff for the centre. In addition, the recruitment process was found to now allow for candidates with "relevant" qualifications in line with the ACIMS regulatory notice - Minimal staffing level and qualifications for registration children's residential centres (August 2024).

Following the last inspection in March 2023, there was evidence provided to the inspector detailing the discussions in management meetings around how to utilise the on-call system to ensure it was most efficient and effective for the purpose required. The inspector reviewed the on-call policy and procedure and found that the procedure as discussed in the inspection report of 2023 had changed to ensure that social care leaders were not on call to their own centre whilst they were also working. The inspector reviewed significant event notifications (SEN) which evidenced that where on-call was utilised, this was specified in the SEN. The inspector was further provided with evidence of discussions with the funding body to approve remuneration for the facilitation of on-call. This matter was ongoing at the time of the CAPA review. There was sufficient evidence provided for the inspector to find that the actions under this standard were implemented.

| **Compliance with Regulations** | |
|---|---|
| **Regulation met** | **Regulation 6**<br>**Regulation 7** |
| **Regulation not met** | **None identified** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **Standard 6.1** |
| **Practices met the required standard in some respects only** | **Not all standards under this theme were assessed** |
| **Practices did not meet the required standard** | **Not all standards under this theme were assessed** |