An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 109**

**Year: 2021**

# Inspection Report

| | |
|---|---|
| **Year:** | **2021** |
| **Name of Organisation:** | **Positive Care Limited** |
| **Registered Capacity:** | **Two young people** |
| **Type of Inspection:** | **Announced** |
| **Date of inspection:** | **19th, 20th & 21st July 2021** |
| **Registration Status:** | **Registered from 05th October 2021 to 05th October 2024** |
| **Inspection Team:** | **Joanne Cogley**<br>**Anne McEvoy** |
| **Date Report Issued:** | **14th September 2021** |

# 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 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 in October 2015. At the time of this inspection the centre was in its second registration and in year three of the cycle. The centre was registered without conditions from the 05th October 2018 to 05th October 2021.

The centre's purpose and function was to accommodate two young people of both genders from age thirteen to seventeen years on admission who are deemed as higher risk and in need of additional supports than those referred to multi-occupancy centres. The centre does not endorse a particular model of care but has a care framework which outlines the principles of therapeutic approaches and models which should underpin placements and overall therapeutic care. The model of care was relationship based and had four pillars: entry; stabilise and plan; support and relationship building; and exit. This model included work on trauma and family relationships while setting meaningful life goals for the young person. There was an emphasis on understanding the young person's behaviour and helping them to learn healthy alternatives. There were two young people living in the centre at the time of the inspection.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| 2: Effective Care and Support | 2.2 |
| 3: Safe Care and Support | 3.2, 3.3 |
| 5: Leadership, Governance and Management | 5.2, 5.3 |
| 6: Responsive Workforce | 6.1, 6.4 |

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

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

## 2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 6th August 2021 and to the relevant social work departments on the 6th August 2021. 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 20th August 2021. 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: 109 without attached conditions from the 05th October 2021 to 05th October 2024 pursuant to Part VIII, 1991 Child Care Act.

## 3. Inspection Findings

**Regulation 5: Care Practices and Operational Policies**

**Theme 2: Effective Care and Support**

**Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.**

At the time of inspection there were two young people residing in the centre. One young person moved to the centre in October 2020 and a care plan followed their admission. A follow up child in care review was held in June 2021 and the centre was still awaiting the care plan from this review. At the time of this inspection this young person did not have an assigned social worker and the team leader was on sick leave. The inspectors spoke with the duty social care worker who was unsure of a timeframe for the case being allocated to a social worker.

The second young person in placement had a child in care review meeting in December 2020 and June 2021 and the centre had not received an updated care plan from either despite a number of requests for same. Inspectors spoke with the newly appointed social worker for this young person who cited a delay in admin work following the recent HSE cyber attack. The regional manager for the organisation confirmed they had written to the team leader in both cases and were still awaiting a response to same. They confirmed they would write to the principal social worker in the coming weeks if a response was not received.

In both instances the centre manager had recorded minutes of the review meetings and these were evidenced on file; however these had not been shared with the social work department to allow them to agree or dispute any of the placement goals. The centre manager should ensure in the absence of Tusla care plans and Tusla minutes for child in care reviews that they share their meeting records with the social work department for agreement. Inspectors saw evidence on file of young people being encouraged to attend their review meetings and where they chose not to, work was completed with them in advance to ensure their views were represented at the meeting and their voices heard and feedback was provided after the meeting. Inspectors offered to speak with both young people but only met with one young person during the course of inspection. They confirmed they can attend their review meetings should they wish to do so and they understood the purpose of their placement.

Each young person had an up to date placement plan on file that was prepared by the centre manager and updated by the keyworker. These placement plans incorporated goals from the minutes of the recent child in care review meetings and were drafted on a quarterly basis. Inspectors found placement plans to be linked to individual work being completed with the young people. One social worker interviewed confirmed that the placement plans supported the aims and objectives of the care plan. There was also evidence of individual work records being completed with young people that focused on the goals they wished to achieve for the month ahead and this was then incorporated into the placement plan.

Inspectors found each of the young people had access to the appropriate specialist services they required. There was evidence that young people were facilitated to attend specialist supportive services such as therapy and counselling, CAMHS and youth diversion projects. Both young people had an appointed external psychologist who was working with them. In one case the psychologist had completed work with the staff team also in relation to approaches to use with the young person.

Inspectors found from a review of care files, interview with one allocated social worker centre management and staff that there was effective communication between these parties and regular professional meetings were occurring. The centre manager highlighted that in the case where they had to contact duty social work, they always got a response without issue.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 5** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **Not all standards were assessed** |
| **Practices met the required standard in some respects only** | **Standard 2.2** |
| **Practices did not meet the required standard** | **Not all standards were assessed** |

- The centre manager should ensure in the absence of Tusla care plans and Tusla minutes they share their meeting records with the social work department for agreement.

## Regulation 16: Notification of Significant Events

## Theme 3: Safe Care and Support

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

Inspectors reviewed centre records and spoke with staff members and found there to be a positive approach towards behaviour management within the centre. All staff members interviewed were aware of the centre's policy on the approach to behaviour management. Inspectors found evidence of rewards being utilised. The centre's approach to consequences was to discuss the event after the fact with the young person. There were no sanction/rewards records completed since April 2021 in the centre and this needs to be reviewed. Inspectors also saw evidence of positive significant events being reported for young people. One social worker interviewed as part of the inspection process confirmed the centre had a positive approach to behaviour management and were notified of all issues within the centre in a prompt manner. All staff were trained in a recognised model of behaviour management. Refresher training had been provided throughout the Covid-19 pandemic however only in the theory aspects of this training. The physical elements of this training had recommenced for the team since March 2021.

The centre had an anti-bullying policy in place that staff were familiar with. Inspectors found that young people's meetings were held regularly and although they were held separately due to house dynamics, they addressed how the young people interact and they were supported to develop their relationships with each other. One young person interviewed and one social worker interviewed confirmed they had no concern in relation to bullying within the centre. Inspectors found through interviews and file review that staff members were attuned to the young people's needs and were aware of the underlying causes of behaviours and sensitive to what was going on for the young people.

Evidence was available to show that each child was supported to develop their understanding of behaviour that challenges. This was completed through life space interviews (LSI's) after incidents of challenging behaviour. Inspectors found in a number of incidents that LSIs were being completed by staff members in the days following the incident however these staff members had not been involved in the incident. One goal of the LSI is to rebuild the relationship between the adult and young person and the centre manager must ensure, where possible, the LSI is

completed between the young person and the staff members directly involved in the incident.

Each young person had an Individual Crisis Management Plan (ICMP) on file which recorded current behaviours, triggers, high risk behaviours and safety concerns along with de-escalation strategies.

Inspectors found that handover meetings were being recorded and held a significant amount of information relating to each young person. In a sample of handover records reviewed inspectors found conflicting information in relation to the frequency of night-time checks on young people. The minutes for one record also appeared to be copied and pasted from previous minutes due to reflecting a weekend day as opposed to a weekday. The centre manager must ensure all handover records are utilised appropriately for planning with accurate and up to date information.

The centre had a number of auditing systems in place which included a review of behaviour management in the centre. Inspectors reviewed a sample of these audits and were satisfied that there were appropriate internal and external mechanisms in place to ensure there was sufficient oversight of the centre's approach to managing behaviour.

The centre had a written policy on the use of restrictive procedures. At the time of the inspection there were restrictive procedures in place including restrictive apps on phones, live night checks, bedroom door alarms and the use of physical restraint. One social worker interviewed confirmed they were aware of the use of restrictive practice in the centre and that they review its requirement regularly with the centre manager and ensure it did not impinge on the young person's rights.

Inspectors found that the restrictive practises in use were risk assessed in the context of why they were being used ie: concerns around internet usage, a restrictive app was implemented to monitor usage. Inspectors did not find that restrictive practise in itself was risk assessed to account for the impact it may have on the young person or the review mechanisms in place. Inspectors also found that the live night checks in place at the time of inspection were not identified as a restrictive practice. This restrictive practice had led to complaints from one young person in relation to being disturbed from sleep at night. The centre manager must ensure all restrictive practices are identified and appropriately risk assessed.

The organisation employed a staff member to carry out work with the young people within all centres. This consisted of mainly outdoor pursuits activities. One young person in placement had availed of this service. Inspectors spoke with management

and staff to gain a better understanding of the service on offer, however all those interviewed were unclear of the goals and aims of the programme. The centre manager and regional manager were not aware of the full events of what occurred when the young person engaged in this programme and did not have access to the records despite the regional manager confirming they had requested this. The regional manager confirmed that the programme coordinator was reporting directly to the deputy CEO in relation to their role however was unsure if formal supervision and professional development was provided. From a review of some records there was conflicting information referring to the title of the programme. In some instances, it was referred to as 'adventure therapy' however, inspectors noted there was no clinical input or oversight of the programme. In other records it appeared the programme coordinator was being utilised as the second staff member on some days and facilitating family access arrangements and on other occasions the staff member would work with the young person, who was staffed at 2:1, on a lone working basis. Inspectors did not see evidence of lone working risk assessments to support this. The regional manager confirmed the staff member had signed up for a recognised qualification and was currently in year two of four of this course. They also confirmed that child protection and training in a recognised behaviour management model were up to date. The registered provider must ensure that there is a clear framework in place for this programme and that all management and staff are aware of same and have the knowledge and understanding of the purpose of the programme.

**Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.**

Inspectors were satisfied that an open culture was promoted in the centre. Staff members interviewed were aware of the whistleblowing policy and were confident they could approach management and senior management if required. Inspectors found that young people's meetings were held regularly and although they were held separately due to house dynamics, it was addressed how the young people interact and they were supported to develop their relationships with each other.

Inspectors spoke with one young person and reviewed both young people's questionnaires and found they could identify members of staff that they could speak with if they had an issue or concern. They reported that they were aware of the centre's complaints process and had received responses to complaints raised.

There was evidence across a range of records including care plans and placement plans that the centre consulted and sought feedback from parents, social workers and other relevant professionals to determine their views on the quality of care being provided. The centre maintained appropriate contact with families through telephone contact and facilitated family visits. The centre had worked exceptionally hard in developing a relationship with one young person's parent and the social worker commended them on these efforts. The social worker interviewed stated that the centre management liaised with them regularly and they were satisfied with the progress the young person had made in their placement. The regional manager stated that an online survey link had recently been sent to all social workers and the organisation intended to collate the feedback from these surveys and use them to inform improvements in the service in the second half of 2021. Inspectors were provided with the quality review completed in 2020 and found this to take into account feedback from young people both within the service and from those who had left; however it did not include any feedback received from other significant people or professionals involved in the young people's care.

The centre had a policy on the notification, management and review of incidents and inspectors were informed by one social worker that all incidents were reported in a prompt manner both via phone and e-mail. There was evidence of oversight by the manager and regional manager who reviewed and commented on the management of all incidents. Incidents were discussed at team meetings and in staff supervision and learning was communicated to the staff team. Inspectors saw evidence of three recent SERG (significant event review group) meetings where approaches were reviewed, risk was discussed and alternative supports implemented for young people and staff; however there was a lack of written evidence to show the follow through of these being discussed with the wider team to make them aware of learnings and any changes required. It was also noted in a recent audit that all incidents with a risk rating over 15 must result in a SERG meeting and that this wasn't occurring consistently and should be reviewed. The centre manager and regional manager must ensure they are following the organisation's policy and procedure in relation to carrying out significant event reviews and that all learnings from same are communicated to the wider staff team.

| Compliance with Regulation | |
|---|---|
| **Regulation met /not met** | **Regulation 16** |

| Compliance with standards | |
|---|---|
| **Practices met the required standard** | **Not all standards were assessed** |
| **Practices met the required standard in some respects only** | **Standard 3.3**<br>**Standard 3.2** |
| **Practices did not meet the required standard** | **Not all standards were assessed** |

**Actions required**

- The centre manager must ensure, where possible, the LSI is completed between the young person and the staff members directly involved in the incident.
- The centre manager must ensure all handover records are utilised appropriately for planning with accurate and up to date information.
- The centre manager must ensure all restrictive practices are identified and appropriately risk assessed.
- The registered provider must ensure that there is a clear framework in place for the outdoor activity programme in place in the organisation and that all management and staff are aware of same and have the knowledge and understanding of the purpose of the programme.
- The centre manager and regional manager must ensure they are following their policy and procedure in relation to carrying out significant event reviews and that all learnings from same are communicated to the wider staff team.

**Regulation 5: Care Practice s 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.**

At the time of the inspection the centre manager had been in post since September 2019. The deputy manager had been in post since September 2019 also, however had recently been promoted to the position of unit manager in another centre within the organisation. The social care leader was promoted to deputy manager and a staff member who previously worked in the organisation was returning to the role of social care leader. These changes all took effect during the week of inspection. The centre manager was experienced in their role and had appropriate qualifications to hold the post. During the course of the inspection, it was evident that leadership was demonstrated by the centre manager. This was supported through interview with the staff members who stated that the centre manager was knowledgeable, approachable and very committed. Inspectors found evidence of leadership on reviewing documents within the centre, where centre manager comments were clear, challenging of practice and supportive of staff efforts. The only area where leadership was not effectively demonstrated was through the handover process. Handover occurred at 8am daily and inspectors were informed that where a social care leader or deputy manager was not on shift then the centre manager would phone in to the unit to partake in handover. Inspectors did not find any written evidence to show when this occurred nor was there evidence of guidance or direction from the centre manager to the staff team. The centre manager must ensure where they partake in meetings remotely this is recorded on the centre records and their input is noted.

The management structure included a centre manager, deputy manager and child care leader and was appropriate to the size and purpose and function of the centre. The centre had procedures in place for designated people to contact in case of an emergency and operated an effective on call system.

There were clearly defined governance arrangements and structures within the centre, however the centre manager must ensure the centre organisational chart on the noticeboard is updated to reflect the recent in house staffing changes. All staff

interviewed were aware of all management levels within the organisation and were clear on their respective roles and responsibilities. All staff members interviewed confirmed they had received job descriptions and contracts. There was a record of designated task lists advising of duties appropriately delegated to staff members within the centre. The centre manager held the overall executive accountability for the delivery of service and it was evident from audits and documents examined that they had oversight on all areas of practice.

The centre's policies and procedures presented for inspection were updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence of an on-going review of policies and procedures by both the organisation and by external consultants. Staff members had received refresher training in the centre's policies and procedures in March 2021 and there was evidence of these being discussed regularly in team meetings.

The centre had a risk management framework in place for the identification assessment and management of risk. The centre maintained a risk management folder in which specific risks were identified and assessed. Staff and management demonstrated a good knowledge of risk associated with young people in the centre. The organisation's policy on risk management categorised risk into three areas: corporate, centre and young people risks. The centre risk register was attached to the statement of purpose for the centre. From review of this risk register, risks identified and assessed were generic risks and appeared across the majority of SOPS for the organisation. There was no mention of risks in relation to potential upcoming loss of placements for young people or a recent covid-19 outbreak. The centre manager and regional manager must ensure that risk assessments address risks specific to the centre and not just generic risks.

The regional manager confirmed there were appropriate service level agreements in place and that annual reports were provided to the funding body.

Inspectors spoke with the centre manager and staff in relation to the ongoing Covid-19 pandemic and found evidence of a number of measures that were put in place by the organisation in response to the crisis. Staff members confirmed they had full access to personal protective equipment, cleaning materials and sanitiser as required. Staff stated they felt safe in their place of employment. The centre had a Covid outbreak in January 2021. During this time a number of staff were absent and the centre operated on double cover for a period of two weeks until all staff were fully recovered. During this time the young people were also self isolating. The young

person inspectors spoke with stated this was a difficult period of time for all involved but that they were supported through isolation and provided with TVs, games etc to keep them occupied. Inspectors reviewed a sample of cleaning records and found these to be inaccurate. The records for the day of inspection had already been completed in advance for that night. Inspectors also noted the handles and doors were not being effectively cleaned down within the centre with visible dirt surrounding the handles in areas of high traffic volume. The centre manager must ensure the organisations covid-19 cleaning protocols are adhered to within the centre.

**Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.**

The centre had a statement of purpose that clearly described the model of care together with the aims and objectives of the centre, the range of services available, the arrangements for the wellbeing and safety of children within the centre and the numbers of management and staff employed in the centre. The statement of purpose reflected the day-to-day operation of the centre. Inspectors found that it was clearly understood by staff members and its vision and ethos implemented on a day-to-day basis. The review of the statement of purpose occurred upon the admission or discharge of a young person or as risk changed within the centre. Inspectors noted that the statement of purpose included young people's full names and ages which may be considered a breach of data protection due to the requirement under the National Standards to ensure the statement of purpose is publically available. This issue had been noted in previous inspections in 2021 within the organisation and both emails and verbal feedback had been shared highlighting this issue however action had not been taken within this centre. The issue was rectified on the day of inspection and inspectors were given an up-to-date statement of purpose. The regional manager must ensure the Statement of Purpose is reviewed to account for any potential data breaches. Information about the centre was also detailed in young people's booklets and parent's booklets.

The statement of purpose clearly outlined the centre's model of care and staff members both in interview and through their questionnaires demonstrated a clear understanding of the model of care. Staff members had received training in the centre's model of care with regular refresher training being provided.

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

| Compliance with standards | |
|---|---|
| **Practices met the required standard** | **Not all standards were assessed** |
| **Practices met the required standard in some respects only** | **Standard 5.2**<br>**Standard 5.3** |
| **Practices did not meet the required standard** | **Not all standards were assessed** |

**Actions required**

- The centre manager must ensure where they partake in meetings remotely this is recorded on the centre records and their input is noted.
- The centre manager and regional manager must ensure that risk assessments address risks specific to the centre and not just generic risks.
- The centre manager must ensure the organisations covid-19 cleaning protocols are adhered to within the centre.
- The regional manager must ensure the Statement of Purpose is reviewed to account for any potential data breaches.

## Regulation 6: Person in Charge
## 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.

Inspectors found that workforce planning was adequately addressed through both audits and management meetings. The organisation had recently developed a new management meeting template which was more comprehensive and allowed for senior management oversight as this was on the organisation's online IT system.

At the time of this inspection there were 12 full time contracted staff members, with a new social care leader due to commence the week following inspection. Four of these staff members were on a full time fixed term contract. Nine staff members held a

social care qualification, two held a social science qualification and one was awaiting results of their final year of a social care degree. From a review of staffing information submitted there was a mix of experience evident on the team. Overall, there was an average length of service on the team of 20 months. Six staff members had been recruited since January 2021. Inspectors reviewed these personnel files and found them to be appropriately qualified but lacked experience with some only having placement experience. The remaining six staff members on the team had worked in the organisation for approximately 2-3 years therefore allowing for an experience balance within the team. The regional manager must be mindful of the experience mix moving forward should an experienced member of the staff team resign.

The centre manager confirmed that both young people within the centre were staffed on a 2:1 basis i.e., two staff to one young person. The centre manager highlighted that this came into effect when one of the young people was admitted in October 2020. From the 24th October 2020 to 16th May 2021 the centre made changes to how one of the 16 hour shifts was being utilised based on their assessment of the needs of the unit. This was being utilised as a split shift. This meant one young person was staffed on a 1:1 basis until 4pm daily when the second staff member came on shift. It was highlighted by the National Private Placement Team to the organisations senior management in May 2021 that the 16 hours could not be utilised for split shifts therefore from the 17th May to date the centre utilised full day shifts with four people on daily. During this full period (Oct-present) the centre also required the use of a live night shift. Prior to the 16th May the split shifts were being used for the provision of a live night shift. Since the recommencement of full day shifts (17th May) the day staff have been completing live night checks thus meaning on a 24 hour shift, staff get a maximum of 4 hours sleep. This issue had been highlighted previously from the Inspector Manager to the Client Service Manager and must cease immediately. Should a live night be deemed necessary then a dedicated person working those allocated hours must be recruited. The social worker for one young person confirmed while they were aware the live nights were in place they were not aware of the arrangements for staff to stay awake throughout the night and did not support this practice.

From a review of the rotas from the 17th May inspectors found two occasions where the full staff quota was not on shift, on these occasions there were three staff members available when there should have been four staff. For the period 24th Oct to the 16th May there were significant gaps on the rota. For this period of 206 days the shift pattern was only adhered to on 90 of these days

Inspectors reviewed rotas from October 2020 to July 2021 and found that 28 staff had worked in the centre during this period. This is in contrast to the staff information sheet provided to inspectors which identified 13 contracted staff and 2 relief staff being utilised in the centre. Due to this lack of information whilst on site, inspectors did not have the opportunity to review relief staff files to assess if all were appropriately qualified. The two relief staff files that were reviewed found one of the two to be appropriately qualified. The second staff member had no qualifications but had been accepted onto a recongised course for September 2021 and inspectors saw correspondence confirming same.

The organisation had arrangements in place to promote staff retention. They provided training, education assistance funding, access to healthcare packages and an employee assistance programme. The inspection information form provided to inspectors highlighted the centre had two staff leave since the last inspection in September 2020. One staff member was promoted to another unit and the second staff member left to pursue work elsewhere. Inspectors reviewed this staff members exit interview and found a number of concerning issues highlighted in it. Inspectors spoke with the regional manager in relation to this and they noted a number of changes were made in response to this feedback. Inspectors did not see evidence of this feedback being utilised for learning purposes within management or team meetings. The regional manager must ensure that feedback from exit interviews is used for learning purposes.

There was a formal on call policy and procedure in operation which staff stated was accessible and responsive to their needs.

**Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.**

The organisation provided a range of training and development opportunities to all staff members that were appropriate to their role. Along with the required mandatory training, training was provided in additional areas such as placement planning, drug awareness, attachment, medication management, key working and the organisation's policies and procedures. All staff members training certificates were stored on their personnel file.

Inspectors noted from a review of team meeting minutes that these were a forum for learning and development. Elements of training and policy reviews were

incorporated into these meetings. Evidence was available to show the organisation's training department, regional manager and client service manager all had input into meetings for training and developmental purposes and these meetings were well attended. Staff members interviewed confirmed that the training department had oversight on all training needs and would inform staff members three months in advance of renewal dates for booking training. The regional manager and centre manager had oversight of training needs within the team through an online system which identified areas staff were yet to be trained in or needed refresher training.

There was a formal induction policy in place. New staff members attended an organisational induction and training programme over the course of five days. They also then completed a house specific induction prior to commencing their first shift. Inspectors reviewed the in-house inductions for the most recent six employees and found these to have been comprehensively carried out by the centre manager.

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

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **Standard 6.4** |
| **Practices met the required standard in some respects only** | **Standard 6.1** |
| **Practices did not meet the required standard** | **Not all standards were assessed** |

**Actions required**

- The regional manager must be mindful of the experience mix moving forward should an experienced member of the staff team resign.
- The regional manager must ensure that feedback from exit interviews is used for learning purposes.
- The centre manager and regional manager must ensure the staff information sheet provided for inspections accounts for all staff members who have worked in the centre and not just a selection of staff members.
- The registered provider must ensure the practise of staff staying awake throughout the night ceases. Should a live night be deemed necessary then a dedicated person working the allocated hours must be recruited.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| 2 | The centre manager should ensure in the absence of Tusla care plans and Tusla minutes they share their meeting records with the social work department for agreement. | All meeting records have been shared with social work departments and also guardian ad litems for the young people. This was completed on 29/07/2021 | Going forward any meeting records completed by the centre will be forwarded to the relevant social worker. |
| 3 | The centre manager must ensure, where possible, the LSI is completed between the young person and the staff members directly involved in the incident.<br><br>The centre manager must ensure all handover records are utilised appropriately for planning with accurate and up to date information. | This has been addressed with the wider team through the forum of a team meeting and emphasis will also be placed on LSI's conducted through weekly link meetings Discussed in team meeting on 03/08/2021<br><br>Unit manager has reviewed handover documents to ensure correct and accurate information with appropriate planning is in place. | The centre manager when reviewing documentation will review those undertaking the LSI and will specifically ensure those involved in the incident strive to engage with the young person in completing the LSI<br><br>Unit manager will review handover documents daily prior to the formal handover taking place and will be in attendance for handovers during their working week. |

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| | The centre manager must ensure all restrictive practises are identified and appropriately risk assessed.<br><br>The registered provider must ensure that there is a clear framework in place for the outdoor activity programme in place in the organisation and that all management and staff are aware of same and have the knowledge and understanding of the purpose of the programme.<br><br>The centre manager and regional manager must ensure they are following their policy and procedure in relation to carrying out significant event reviews and that all learnings from same are communicated to the wider staff team. | Restrictive practices have been appropriately recorded as control measures within the young persons Individual risk management plans.<br><br>The Outdoor adventure programme is not attached to the Clinical Department and any documents that caused confusion in this regard were updated on 1st August 2021 with any reference to Therapy removed.<br><br>All incidents are risk rated and are reviewed as part of daily risk reports for the need for a SERG depending on risk rating. However if trends or patterns are identified in reoccurring incidents of lower value a SERG could be conducted if deemed appropriate. Learning from SERG | Restrictive practices will be reviewed in weekly link meetings to ensure they are relevant and appropriate.<br><br>The specific criteria/ framework as to when a young person can avail of outdoor pursuits within the outdoor adventure programme is currently being reviewed as the intervention has proven very popular with young people and demand is high. This review will be completed before the 1st October 2021 with a decision then made as to whether to increase the scope of the programme and recruit a second person to meet demand.<br><br>Daily risk report, service governance and regional governance reports along with quality assurance audits will provide for oversight and governance to ensure policy and procedure is adhered to in relation to carrying out significant event reviews. |

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| | | reviews are be shared with the team in team meetings. | |
| 5 | The centre manager must ensure where they partake in meetings remotely this is recorded on the centre records and their input is noted. | Unit manager to include name on the handover form in the messages section to note attendance. | Going forward the unit manager will utilise the notes section to note attendance but handover times will be reviewed to ensure that it appropriately allows for management involvement and oversight. |
| | The centre manager and regional manager must ensure that risk assessments address risks specific to the centre and not just generic risks. | Statement of purpose has been updated to reflect risks relevant to the centre. | Weekly link meetings review statement of purpose documents for changes and updates. |
| | The centre manager must ensure the organisations covid-19 cleaning protocols are adhered to within the centre. | Unit manager is reviewing Covid 19 protocols at handover daily to ensure protocols are followed. | Unit manager to utilise daily handovers and walkaround to ensure covid 19 protocols are followed. |
| | The regional manager must ensure the Statement of Purpose is reviewed to account for any potential data breaches. | Review has been undertaken and any breaches of data have been removed. | Guidance organisationally has been circulated as to how the document should be used and completed to ensure there is no breaches. |

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| 6 | The regional manager must be mindful of the experience mix moving forward should an experienced member of the staff team resign. | When contracts are being filled we will strive to maintain the experience and skill mix within the staff team. | When contracts are being filled we will strive to maintain the experience and skill mix within the staff team. |
| | The regional manager must ensure that feedback from exit interviews is used for learning purposes. | Feedback from exit interviews will be directly utilised to inform shared learnings where appropriate. | Feedback from exit interviews will be directly utilised to inform shared learnings where appropriate. |
| | The registered provider must ensure the practise of staff staying awake throughout the night ceases. Should a live night be deemed necessary then a dedicated person working the allocated hours must be recruited. | An alternative roster has been developed which will be implemented should live night checks be required. This roster will provide for a dedicated staff member to complete these checks | Should live night checks be required an alternative roster will be implemented for the duration of the period with a dedicated staff member working an 8-hour night shift to complete these checks |