An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 113**

**Year: 2021**

# Inspection Report

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|---|---|
| **Year:** | **2021** |
| **Name of Organisation:** | **Positive Care Ltd** |
| **Registered Capacity:** | **Two young people** |
| **Type of Inspection:** | **Announced** |
| **Date of inspection:** | **06th & 07th October 2021** |
| **Registration Status:** | **Registered from 11th January 2022 to 11th January 2025** |
| **Inspection Team:** | **Catherine Hanly**<br>**Lorraine Egan** |
| **Date Report Issued:** | **03 February 2022** |

# 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 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 11th of January 2016. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from 11th January 2019 to 11th January 2022.

The centre was registered to provide medium to long term care for a maximum of two young people aged between 13-17 on admission. Their model of care was based on theoretical approaches underpinned by four pillars of care; entry, stabilise and plan, support, relationship building and exit. The framework aimed to provide young people with stability, security, self-awareness, independence, self-sufficiency, appropriate coping skills and education. 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 |
|---|---|
| 2: Effective Care and Support | 2.2 |
| 3: Safe Care and Support | 3.2, 3.3 |
| 5: Leadership, Governance and Management | 5.2 |
| 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

Inspectors consulted with their line management following the completion of the inspection and assessment of findings therein. Following delivery of preliminary findings to centre management, a proposal was made by the inspectors to the Alternative Care Inspection and Monitoring Service (ACIMS) Registration Committee to attach a condition with immediate effect to the centre's registration. This proposal was referred to the National Registration Enforcement Panel (NREP) for consideration. It was accepted and approved by the NREP on the basis that preliminary findings were that the centre was not operating in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies. Centre management and proprietors were informed on the 18th of October 2021 of the decision by the NREP to propose to attach a condition to the centre's registration that there be no further admissions to the centre until the inspection process was completed, the corrective and preventive action plan (CAPA) was implemented, and the centre was operating in full compliance with the relevant regulations. The proprietors accepted this decision by the NREP.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 22nd of October 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 4th of November 2021 and subsequently submitted a range of documents requested that provided evidence of actions taken at that time as identified in the CAPA. The inspectors, and the NREP, were satisfied with the CAPA and the supporting information provided and agreed that the condition that had been applied to the centre's registration could be removed. The registered proprietor was informed of the decision to remove the condition on 1st of December 2021. However, on the review of all this information, it is the decision of the Child and Family Agency to register this centre, ID Number 113: with attached conditions from the 11th of January 2022 to the 11th of January 2025 pursuant to Part VIII, of the 1991 Child Care Act.

***Regulation 5: The registered proprietor and person in charge of a centre shall satisfy the relevant health board that appropriate and suitable care practices and operational policies are in place, having regard to the number of children residing in the centre and the nature of their needs.***

*and*

***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.***

- **The registered proprietor will take appropriate measures to ensure that the centre management systems are audited with a view to assuring the inspectorate that the governance of the centre is effective.**

- **The audit should focus on implementation of organisational policy and of care management practices.**

- **A report of the audit and the implementation of any ensuing findings should be provided to the inspectorate for consideration.**

- **This task to be completed within 3 months of the condition being attached.**

## 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.**

The care plan on file for the young person in the centre at the time of the inspection was up to date. Inspectors noted that this plan was focused on some of the practical aspects of care provision such as health and attempting to engage the young person in education. There was reference to emotional supports having been sought but declined by the young person and this was identified as an ongoing need. The young person had declined to participate in or contribute to their statutory review process.

The centre's placement plan was updated on a three-monthly basis and took account of the actions identified in the statutory care plan. The placement plan allowed for input by the child, their social worker and family members where they were involved. The young person had had an opportunity to identify their own goals within the placement plan and there was evidence that actions had been put in place to assist them in achieving these. There was evidence that key working with the young person was tracked through the placement plan review mechanism to achieve identified goals and the young person's progress was discussed at team meetings.

However, inspectors noted that there was little change in the placement goals identified for the young person from one plan to the next, a matter that had been highlighted in another centre within the company this year; and the amount and type of key work and its effect wasn't consistently detailed in plans. The placement plans reviewed by inspectors frequently noted a high level of non-engagement by the young person in any of the services offered to them. The most recent placement plan did acknowledge that due to the non-engagement, smaller more achievable goals should be identified yet there was no input by the company's clinicians and the plans noted that there was no need for therapeutic or behaviour support plans for the young person despite this non-engagement. An earlier placement plan also did not account for therapeutic input despite its reference in the accompanying statutory care plan at that time. Inspectors noted that in the July placement plan it identified that with the ongoing non-engagement there was also substance misuse issues that required addressing. Inspectors found that this young person had been demonstrating their

feelings through their actions and behaviour and there was a limited response to this by the team. It was stated that behaviours engaged in by the young person ultimately led to a decision to discharge them. The young person at that time made threats of suicide in response to this, whilst action was taken in response to that at the time, inspectors were of the view that a more proactive and consistent approach to the management of escalating behaviours may have lessened the likelihood of this outcome. A more robust internal review mechanism by centre management with input from professionals where relevant must be implemented to assist the care team to better determine when additional supports are required to meet the identified needs of the child and respond in a more proactive and individualised manner.

Inspectors noted that there were good and consistent efforts by the management and staff team to consult with, inform and regularly communicate with the allocated social worker. Centre management did state that at times the social worker could be difficult to contact or return request for contact. There had been a period during the summer months when the social worker was on leave and efforts to secure a multi-disciplinary meeting had been made by the centre. Inspectors made multiple efforts to secure a meeting with the social worker however were unsuccessful.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 5** |
| **Regulation not met** | **None Identified** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **None identified** |
| **Practices met the required standard in some respects only** | **Standard 2.2** |
| **Practices did not meet the required standard** | **None identified** |

**Actions required**

- Centre management must review their placement planning processes to ensure that this mechanism adequately identifies the presenting needs of individual young people and supports a coordinated approach to the provision of effective care and support.

**Regulation 16: Notification of Significant Events**

**Theme 3: Safe Care and Support**

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

The centre had a 24-page policy document informing staff practice in relation to promoting positive behaviour. This document was informed by national policy, evidence-based guidelines and legislation. There was an anti-bullying policy in the centre, however this was not relevant at the time of the inspection as the young person was residing there on their own.

Inspectors found that staff and management did not clearly demonstrate a good understanding of the positive behaviour policy document or indeed the centre's care framework and it was not referenced by them as a guiding document in their work. Whilst elements of the policy had been implemented in practice including individual crisis management plans (ICMP), and daily routine in the form of working guidelines; overall, the number of documents within the file that related to behaviour management was disproportionate to the description by management and staff of interventions in practice. Inspectors did not find that the policy on promoting positive behaviour was realised in full in practice. There was limited evidence to demonstrate that staff were consistently looking beyond the behaviours being displayed to support the young person in understanding and managing their own behaviours. Some life space interviews (LSI) had been conducted more recently by the centre manager to assist the young person to understand their behaviour. However, many of the behaviours being displayed by the young person including racial, verbal and physical abuse towards staff were not being actively targeted by staff.

Inspectors found that other aspects of the policy, specifically the implementation of therapeutic or behavioural support plans as required, had not been adhered to. The centre's policy document states that a behaviour support plan (BSP) may be drawn up to "*...target any maladaptive behaviours that affect the quality of life for the young person...*" and further that this plan "*...aims to support the team to help change these maladaptive behaviours and replace with appropriate positive behaviours...*". Whilst the centre manager was of the view that a BSP was not required for this young person at any stage, the escalating at-risk behaviours and

behaviours bordering on criminality certainly fit the criteria for "maladaptive behaviours". The young person's own placement plan acknowledged that the young person was absconding and engaging in substance misuse. There was evidence that the care team in the centre had liaised with the company's clinical psychologist for guidance and they had provided an information session to the team however they had not devised an individualised therapeutic plan. The centre manager had not sought the input of the company's behaviour management specialist, believing that this was not required, but the development of a behaviour support plan may indeed have produced useful guidance to the team.

At the time of this inspection, calling the Gardaí had become a behaviour management technique. Its use was not always in accordance with the centre's policy on the use of the Gardaí and on occasions where they were requested to arrive to the centre, the records of the event didn't demonstrate that all other de-escalation techniques had been utilised. Centre management must review their own policy documents and mechanisms by which behaviour support and safety plans are determined to be required to support a young person's behaviour and placement. Centre management must also ensure adherence to policy.

Inspectors found that significant events were being reviewed on a regular basis and there was evidence of the learnings from these individual events being shared with the care team in this centre at team meetings and being relayed in hand over. There was also shared learning taken from experiences and events occurring in other centres within the company provided by the regional manager during attendance at team meetings. There was no evidence of the registered provider having undertaken an audit of the provision of positive behavioural support in this centre and this must be undertaken as a priority.

There were some restrictive practices in place for the young person at the time of this inspection. These were deemed a necessary safety measure in response to escalating unsafe behaviours being displayed and included daily room searches and no cars on the premises therefore the young person was not permitted access to the house car. Staff were aware of their use and understood the reasons for same. A record of these restrictive practices was maintained and regularly reviewed in accordance with the centre's policy. They had been discussed with the young person and they had made a complaint about one which had been promptly responded to. Records indicated that the manager had had conversations with them to support their understanding in relation to the use of such measures.

The training records reviewed by inspectors indicated that the management and staff team had been provided with training in a recognised behaviour management programme that included the use of physical restraints. This was also included in the centre's policy document however staff did not name this training model in interview and the language of this programme was not consistently evident in records reviewed. Staff did not specifically name physical interventions as a restrictive practice, and although there had been none recorded with the young person at the centre, it is important that the manager ensures this awareness. Inspectors noted that staff still referred to individual crisis management plans (ICMP) rather than crisis support plans and centre management must ensure that training provided is in the most recent version of this programme and that plans area adapted accordingly. The ICMP on file had a 'creation date' of January and a review date of October, management explained that this document had been reviewed on a monthly basis in the intervening months identified here however when inspectors asked staff about interim documents, staff were not aware of any. The centre's policy document stipulates that an ICMP should be reviewed *"...at least weekly..."* however in practice this was not the case. Centre management must ensure that practice is in adherence with policy in all aspects of behaviour management. They must ensure that staff are familiar with the review and recording mechanisms required and must clearly demonstrate how their interventions are guided by policy.

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

The centre had guiding policies on complaints processes for young people and their parents/significant others. The manager described an annual formal feedback mechanism for social workers and parents. This had been issued to parents and was being prepared to issue to social workers at the time of this inspection and therefore no recent feedback had been received. There were daily opportunities provided to young people to have their views and voice heard on matters relating to provision of care, including at young person's meetings, in general conversations and in meeting with the centre manager.

Inspectors reviewed the centre's complaints register and noted that young people had utilised this mechanism to voice their frustration or dissatisfaction with aspects of the care provision including the wi-fi at the centre, the food choices available and the use of restrictive practices. Inspectors found that staff were not clear about the mechanisms available to them to raise concerns or identify areas for improvement within the centre. Inspectors also reviewed records of events that had been notified

through the centre's own significant event notification system but had not been notified separately as child protection concerns and should have been, given the nature of the events. Inspectors were informed that informal communications about these events had taken place with the Gardaí and the young person's social worker was also aware, however this does not replace the responsibility of a mandated person in reporting the event through the formal channels in accordance with the centre's own policy and procedure. Inspectors were informed after the onsite visit to the centre that these events had been retrospectively notified through the Tusla portal. Although training had been provided to the management and staff team in the area of protected disclosures as part of an overall training piece on safeguarding and child protection, the manager and staff team did not reference the centre's policy on whistleblowing and protected disclosures as a mechanism through which they would be enabled to raise concerns. Given deficits identified through the inspection process in another centre operated by this company in the area of child protection and the apparent lack of responsibility to raise concerns they had regarding practices, it is imperative that the manager and staff team clearly understand their responsibility to raise any concerns they may have. This knowledge should be supported by a clearly understood policy and procedure that is easily accessible.

There was a centre policy on the reporting of significant event notifications (SEN), inspectors found that these events were recorded and reported promptly. As previously mentioned, there was evidence of such events being reviewed via a formal review group mechanism and learning shared with the team following such reviews.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 16** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **None identified** |
| **Practices met the required standard in some respects only** | **Standard 3.3** |
| **Practices did not meet the required standard** | **Standard 3.2** |

**Actions required**

- Centre management must review their own policy documents and mechanisms and ensure that practice in the centre is reflective of these as well as being appropriately responsive to individual needs of young people.

- The registered provider must undertake an audit of the provision of positive behavioural support in this centre as a priority.
- Centre management must ensure that the behaviour management with physical interventions training provided is in the most recent version of this programme and that plans are adapted accordingly.
- Centre management must ensure that the management and staff team have a thorough working knowledge of the behaviour management approach including all intervention techniques and know how these are informed, reviewed and documented.
- Centre management must ensure that practice is in adherence with policy in all aspects of behaviour management.

**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.**

The internal management structure at the centre consisted of an appointed manager and deputy, supported in their respective roles by three social care leaders, one of whom had been appointed approximately two months prior to this inspection. Inspectors found that the structure was appropriate to the size and purpose of the centre. There were job descriptions for each role and each clearly demonstrated an understanding of their individual role and responsibilities. The deputy manager was tasked with taking over the responsibilities of the centre manager in their absence and a clear list of delegated duties was maintained on each occasion of acting up. The centre manager also maintained a list of delegated tasks for each individual staff member relevant to their role. From a review of these delegated duties, it was unclear what level of oversight and follow up took place where tasks had not been completed. Centre management must ensure that if this is an accepted method of accountability then it its overseen robustly.

The registered provider was operating under an older service level agreement with Tusla while ongoing revised contract negotiations. There had been regular meetings

and updates regarding young people's progress and an annual report was submitted to the National Private Placement Team within Tusla. The service provider was awaiting updated information from Tusla regarding the contract and ongoing reporting mechanisms at the time of this inspection.

The centre manager was identified as the person in charge of this centre. They had been in post for a period of two and a half years at the time of this inspection. The manager had an appropriate social care qualification relevant to the role and held a management qualification. The manager was described as approachable and supportive by members of the internal management and staff team. They were based in the centre Monday to Friday working normal office hours and would stay late if required. They were being supported in their role by a deputy manager who supported the oversight of placement planning and key working amongst other tasks. There was evidence of the manager's input to staff practice across records examined and they were available to and supportive of the young person in placement. The manager valued and encouraged a culture of learning within the centre, a value that was shared by senior management. There was evidence of ongoing training being provided to staff but as will be explored further in this report, the quality of this and evidence of retention and implementation was lacking at the time of this inspection. A culture of professional development and promotion was described by centre management and staff in interview and evident in this centre through the promotion of staff to more senior grades; however, inspectors found during interviews with management and staff that there were deficits in ability to demonstrate knowledge of guiding policies and procedures. Senior management must quality assure the mechanisms by which people are promoted to more senior posts within this centre, including the use of formal interview process to ensure that persons appointed to posts have the knowledge ad competencies required to fulfil all aspects of the role.

The centre manager reported to a regional manager and there was evidence that there was regular formal and informal communication happening between centre and regional management level. Some of the staff members and internal management referred to the availability and support of the regional manager in questionnaires. The company's cloud-based IT system enabled the regional manager to have input to records completed at centre level. This system also allowed access for the regional manager and client services manager, if required, to have oversight, and to gather and analyse information contained within. Some changes to governance had occurred as a part of an organisational response to deficits identified in another centre earlier in 2021.

The centre's policies and procedures were formally reviewed in their totality on a two-yearly basis the most recent review having been conducted in July 2020. On a rolling basis, policies were updated as required or following feedback from inspections to ensure adherence with the National Standards for Children's Residential Centres, 2018 (HIQA). The centre manager confirmed that training had been provided to the staff team on the policies and procedures including a recent amendment to the child protection suite of policies. There was evidence that policies had been discussed on a regular basis at team meetings however the evidence from centre management and staff interviews and questionnaires did not demonstrate a working knowledge of and familiarity with the policies and procedures guiding work practices in the centre. As highlighted in relevant areas throughout this report, inspectors found that practices in this centre had not consistently adhered to policy. Senior management must take the necessary action to ensure that staff are familiar with the policies that guide their daily practice and ensure that practice is consistently in adherence with policy and procedure. This is a matter that had been raised with senior management within his company and remains a high-risk area of practice as the current systems in place were not identifying non-adherence to and lack of familiarity with guiding policies and procedures.

There was evidence that there were a range of mechanisms and reporting documents in place that informed the risk management framework at the centre. This included individual risk assessments – per event that a young person participated in; individual risk management plans (IRMP); individual absence management planning; child safeguarding statement; statement of purpose and centre risk registers inclusive of health and safety matters.

There was evidence of risks being reviewed at staff handover and in team meetings, and of discussions with the allocated social worker. Some staff stated that they had received training in risk management. Inspectors found that there was a significant amount of documentation to review and process regarding risk management and the detail within relevant documents was not always consistent. Inspectors found that interventions to mitigate against risks identified were slow to be implemented with no behaviour support plan for the young person, as previously stated, and a safety plan having only been very recently implemented following a serious incident at the centre.

A recent response to risk/management of the young person's behaviour was calling the Gardaí. This decision was not entirely consistent with the centre's own policy on the use of the Gardaí and didn't demonstrate a positive approach to the management

of challenging behaviour. Inspectors reviewed a pre-admission risk assessment completed for a proposed new admission and noted that although risks were highlighted and rated clearly, the interventions aligned to these risks were insufficient and lacked clear direction for the staff team in managing those risks. Whilst centre management was clear about the thresholds for escalation of risk for the attention of senior management and there was evidence that these were discussed at regional manager level, the interventions to address the risks at earlier stages was significantly lacking. The guidance for the staff team in managing risk was not clear to inspectors and staff were not clearly able to demonstrate their understanding of managing risks presented by the young person.

Centre management informed inspectors that recent events had culminated in a decision to discharge the young person to another centre for their safety. Senior management must take the necessary action to ensure that risk management is adequately robust and in accordance with centre policy. The management and staff team must have clearly understood direction regarding interventions to be employed in managing presenting risks.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 6** |
| **Regulation not met** | **Regulation 5** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **None identified** |
| **Practices met the required standard in some respects only** | **Standard 5.2** |
| **Practices did not meet the required standard** | **None identified** |

**Actions required**

- Senior management must ensure that the recruitment policy and processes in place are sufficiently robust to ensure that persons appointed to posts have the qualifications, skills and competencies required to fulfil all aspects of the role.
- Senior management must take the necessary action to ensure that staff are familiar with the policies that guide their daily practice and ensure that practice is consistently in adherence with policy and procedure.
- Senior management must take the necessary action to ensure that risk management is adequately robust and in accordance with centre policy.

- Senior management must ensure that the centre management and staff team has clearly understood direction regarding interventions to be employed in managing presenting risks.

**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.**

The responsibility for workforce planning was shared between centre management and the Human Resource (HR) department within the company. It was regularly discussed at regional manager and centre manager meeting forums and as requirements arose for additional staffing, a liaison with HR took place. The discussions around workforce planning took consideration of the various types of leave that may occur including annual, maternity and study leaves. There were some arrangements in place to encourage staff retention within the company including professional training and continuous development opportunities, access to a formal employee assistance programme, access to healthcare and various supports with educational attendance. Not all staff were able to clearly name the various measures and spoke more to the arrangement that was relevant to them. Centre management could refresh this information for the staff team.

There were three social care leaders and eight social care workers as well as a deputy manager and centre manager named as dedicated to working in this centre at the time of this inspection. Of the eleven staff members, nine had a social care qualification (with one pending graduation from their social care programme), one had a relevant qualification and inspectors are awaiting confirmation of the relevant equivalency of a second social care worker. Recent risk and safety management planning had involved the relocation of a staff member to another centre as they were being targeted by the young person in a manner that was reported to be proactive and aggressive. One of the social care leaders had been covering a short period of leave in another of the company's centres at the time of this inspection also but this did not leave a deficit in the staffing numbers in this centre. A second social care leader had been appointed to their current post without a formal interview process having been employed within the company for a period of four months at the time. Whilst the

interview process is not a specified requirement as per the company's policies, it is an advisable screening mechanism that supports identification of suitably qualified and competent personnel for identified posts. In this situation, the newly appointed social care leader had relevant experience of working in residential care, however it was not specific to children/young people in residential care which is the current specified requirement as per the memo on staffing issued to all providers in February 2020. In this matter, the centre does not comply in full with the regulation governing staffing.

The centre was only accommodating one young person at the time of this inspection and two staff were working a sleepover shift each day which was a 24hour shift plus handover time. As the centre can accommodate two young people and was doing so until late July of 2021, there were occasions where the two sleepover shifts were complemented by an additional day shift consisting of 16hours when there were two young people resident. There was a rolling rota devised and staff knew their working pattern for months in advance. Inspectors found that there was a mix of experience amongst the staff team ranging from two months to twenty years however there was no consideration given to this variance in experience and competency in the development of the staff rota. The centre manager must ensure that the deployment of staff across the rota demonstrates consideration of the competencies and experience levels of the staff team to competently meet the needs of the young people.

There were formalised procedures in place for on-call arrangements at evenings and weekends that were supported by a policy document. This responsibility was shared amongst the centre and deputy managers of four sister houses within one identified operational region of the company. Records of the use of on-call were entered onto the company's recording system by the on-call person.

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

The company had an identified suite of training for all staff as new members coming to work in this centre as part of the formal induction policy and procedure. Mandatory training completed by staff included training in the centre's specified behaviour management programme, report writing, child protection, health and safety, use of the company's online recording system, first aid (online since the commencement of the Covid-19 pandemic), manual handling, fire safety and medication management. Additional training completed by staff included placement

planning, key working, risk management, policies and procedures and sexual exploitation. Training in policies and procedures was not documented on one of the personnel files sampled by inspectors of a newly recruited staff member. The care framework and policies and procedures should be included as a mandatory training piece for all new staff. Staff frequently cited opportunities for training and professional development as a regarded aspect of their work in the centre. Inspectors were informed that staff were expected to attend and complete relevant training whenever it took place irrespective of whether they were scheduled to work that day. This meant that although a staff member may be off duty on a given day, they would be expected to attend training as part of their working week without being compensated with time back.

Training took place on an ongoing basis and regular reminders were issued at staff team meetings and via work emails of requirements to attend. There had been no formal or regularised training needs analysis conducted to determine the specific training needs of this staff team. Inspectors noted from their review of the staff training records that not all staff had completed the same training, with some but not all having completed the training courses listed here. In addition, inspectors noted that much of the training was completed in one day so for example one staff had completed manual handling, fire safety and fire extinguisher and medication management on one day. Inspectors observed that the centre's medication management policy, inclusive of appendices of relevant forms that may have to be filled by staff, ran to 53 pages in length. If the training delivered to staff was inclusive of any discussion of this lengthy policy document, it is difficult to ascertain how three different types of training could be delivered across one day. Centre management must review the type, quality and delivery of training to staff and management in this centre and ensure that optimises the ability of the staff team to implement into practice.

Inspectors did note that training had been delivered to the team as part of an organisational response by senior management to deficits identified in other centres operated by the company. This included child protection and sexual exploitation. Aside from an information briefing delivered by the company's clinical psychologist in June on the area of drug awareness and a second one in this area also planned but not completed at the time of this inspection, there was no training identified or sourced specifically to meet the needs of the young person in this centre. Centre management must conduct a training needs analysis specific to the staff team in this centre and devise a programme of training and development based on the outcome of that assessment. A regular training needs analysis must be undertaken going forward

to ensure that staff are receiving training and development designed to meet the needs of this centre's statement of purpose, care practices and operational procedures.

| Compliance with Regulation | |
|---|---|
| **Regulation met** | **Regulation 6** |
| **Regulation not met** | **Regulation 7** |

| Compliance with standards | |
|---|---|
| **Practices met the required standard** | **None identified** |
| **Practices met the required standard in some respects only** | **Standard 6.1**<br>**Standard 6.4** |
| **Practices did not meet the required standard** | **None identified** |

**Actions required**

- Centre management must ensure that all staff recruited to social care leader level have the required minimum qualification and experience specified.
- The centre manager must ensure that the deployment of staff across the rota demonstrates consideration of the competencies and experience levels of the staff team to competently meet the needs of the young people.
- Centre management must review the type, quality and delivery of training to staff and management in this centre and ensure that optimises the ability of the staff team to implement into practice.
- Centre management must conduct a training needs analysis specific to the staff team in this centre and devise a programme of training and development based on the outcome of that assessment. A regular training needs analysis must be undertaken going forward.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
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| **2** | Centre management must review their placement planning processes to ensure that this mechanism adequately identifies the presenting needs of individual young people and supports a coordinated approach to the provision of effective care and support. | Training was delivered to the centre manager and staff team on the 20th of October, the training that was delivered was placement planning and key working training.<br>The CAPA was discussed with senior management, Centre management and the staff team on the 03rd of November so that all involved understand what is needed going forward to ensure a co-ordinated approach to the provision of effective care and support to young people. | Key- working planning meetings will be held by the centre manager with the key workers at the beginning of each month so that the key working is planned for the month ahead and reflects the placement plan goals and identified target areas for the Y/P. This is to ensure that there is planning at the start of the month and that these goals are linked to the placement plan.<br>These plans will be discussed at team meetings and individual supervisions with staff members to ensure comprehensive understanding amongst the staff team of the needs of young people and a coordinated approach to working with young people.<br>In addition, a Positive Behaviour Support Screening tool has been developed which will allow for Centre Management to |

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| | | | request the Behaviour Analyst to determine if a functional needs assessment is required. Based on this determination a behavioural support plan could be created. |
| **3** | Centre management must review their own policy documents and mechanisms and ensure that practice in the centre is reflective of these as well as being appropriately responsive to individual needs of young people. | There needs to be an ongoing emphasis on policies and procedures going forward in team meetings, the centre manager will ensure that each staff member has a turn at delivering a policy and procedure to the team this is to ensure shared learning. The centre manager will oversee this.<br>The policies and procedures will be discussed in supervisions going forward to aid the staff team in understanding these procedures that are in place and aid the staff member to be able to use these policies and procedures in their daily work within the unit. | Quality Assurance Audits will assess on an ongoing basis how practice in the centre is reflective of and responsive to individual needs of young people. Quality Assurance Audits will include interviews with staff to ensure they are familiar with all aspects of the presenting needs of young people. The Regional Manager will include interviews with staff as part of their onsite governance support visits. |
| | The registered provider must undertake an audit of the provision of positive behavioural support in this centre as a priority. | All future admissions to the Centre will be subject to a documented clinical screening process. A therapeutic assessment of needs document or a screening tool to determine if Positive Behaviour support is required will be completed | To ensure ongoing review of both Clinical and Positive Behaviour Support needs every two weeks the regional manager governance report will assess if there have been any changes to the presenting needs of young people which will require Therapeutic or Positive Behaviour Support. |

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| | Centre management must ensure that the behaviour management with physical interventions training provided is in the most recent version of this programme and that plans area adapted accordingly. | Refresher training in the model of behaviour management (TCI version 7) was delivered to the staff team on 21-10-21. This training was in line with the guidance of the accreditation body.<br>To accurately reflect training as delivered by the training department in TCI version 7 all policies and procedures, training programmes, cloud-based system documents including risk management documents, auditing and governance reports and internal and external communication will now refer to the correct terminology of Individual Crisis Support Plan. The I.T. Department are currently implementing these changes | TCI training will now revert to pre-covid criteria, and all new staff will complete full TCI training in accordance with the guidance from the accreditation body. All refresher training will be completed in accordance with the guidelines as stipulated by the accreditation body.<br>TCI will be regularly reviewed with the staff team going forward and will be discussed at team meetings and supervisions to ensure that there is continued learning from this with all staff members and for it to be used in records to support the staff in working with the Y/P within the unit. |
| | Centre management must ensure that the management and staff team have a thorough working knowledge of the behaviour management approach including all intervention techniques and know how these are informed, reviewed and documented. | Going forward the behaviour management approach which will include the behaviour techniques which will be used in the records for the Y/P by staff members to show what techniques were utilised by the team, there will be ongoing support for the team via supervisions to include behaviour management and promoting positive | This will be ongoing with the centre manager having oversight on all reports to ensure that the behaviour management is always adhered to, this will be discussed at supervisions, team meetings, team incident reviews.<br>Centre Management will ensure that team meetings and individual supervisions with |

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| | | behaviour. The ICMP will be referenced as ICSP and will be reviewed in team meetings in consultation with staff to ensure ongoing review. | staff assess each staff members understanding of policies and training received which are designed to support and guide their work. Quality Assurance audits and regional manager governance reports will provide ongoing oversight to ensure practice is in accordance with policy in relation to all aspects of behaviour management. relation to all aspects of behaviour management. |
| | Centre management must ensure that practice is in adherence with policy in all aspects of behaviour management. | Centre Management give an undertaking to ensure that care practice will be in line with policy in relation to all aspects of behaviour management. Any changes to risk management documents will be clearly communicated to all staff team members. | Quality Assurance audits and regional manager governance reports will provide an additional layer of oversight to support Centre Management in ensuring practice is in accordance with policy in relation to all aspects of behaviour management. |
| **5** | Senior management must ensure that the recruitment policy and processes in place are sufficiently robust to ensure that persons appointed to posts have the qualifications, skills and competencies required to fulfil all aspects of the role. | All future appointments whether external or internal applicants will be subject to a selection process which ensures they have qualifications skills and competencies required to fulfil all aspects of the role | The Recruitment Policy and relevant policies and procedures will be reviewed at regular intervals. |

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| | Senior management must take the necessary action to ensure that staff are familiar with the policies that guide their daily practice and ensure that practice is consistently in adherence with policy and procedure. | Centre Management and staff have received refresher training in TCI, placement plan and key-working, Child protection, Care Framework and risk management policies have been reviewed with the staff team in workshop days. This training has included subsequent testing to assess individual staff members understanding. | The full suite of all company Policies and Procedures is currently under review. It is now recognised that ensuring that these policies are clearly understood and therefore reflected in daily practice requires them to be more streamlined, reduced in volume and user friendly. Changes to key documents have now been made and it is envisaged that changes to the full suite of polices will be completed in Dec 2021. |
| | Senior management must take the necessary action to ensure that risk management is adequately robust and in accordance with centre policy. | The Risk Management Policy document has been reviewed and changes made. The policy document is now a more concise and streamlined document to facilitate clearer understanding from the staff team who are responsible for implementing the policy into practice. | Daily regional manager risk reports, quality assurance audits, regional manager governance reports, weekly management meetings and ongoing training needs analysis reports are in place to support robust risk management processes. |
| | Senior management must ensure that the centre management and staff team has clearly understood direction regarding interventions to be employed in managing presenting risks. | Refresher training in the model of behaviour management was delivered to the staff team (TCI version 7) on 21-10-21. This training was in line with the guidance of the accreditation body.<br>ICSP- will outline clear intervention | Quality Assurance Audits and Regional Manager governance reports will provide an additional layer of oversight to ensure that risk management is robust and that there is ongoing evidence that presenting risks are clearly understood and responded |

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| | | strategies and will ensure clarity in the policy around frequency of review. Management of challenging behaviour policy will clearly outline at what threshold Garda intervention is required. | to appropriately. |
| **6** | Centre management must ensure that all staff recruited to social care leader level have the required minimum qualification and experience specified. | Only staff with the required qualification and relevant experience will be recruited going forward. | The Organisation gives an undertaking that only staff with a social care qualification or a qualification in a related field will be appointed to social care leader positions. Only staff who have three years' experience of working at social care grade with children will be appointed to social care leader positions. |
| | The centre manager must ensure that the deployment of staff across the rota demonstrates consideration of the competencies and experience levels of the staff team to competently meet the needs of the young people. | A new rota will be introduced which will take account of the skills competencies and experience mix of the staff on shift each day. Centre Management will maintain oversight of this rota to ensure that this balance is maintained to ensure that the needs of the young people are met. | Workforce planning will be reviewed on a weekly basis to ensure that roster planning and management of staff leave takes account of the needs of young people. |
| | Centre management must review the type, quality and delivery of training to staff and management in this centre and ensure that optimises the ability of | Centre Management will ensure that team meetings and individual supervisions with staff assess each staff members understanding of policies and training | Centre Management will regularly assess if practice delivery and competencies of the staff team is reflective of the training received. Quality Assurance Auditors and |

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| | the staff team to implement into practice. | received which are designed to support and guide their work. Through team meetings and individual supervisions all staff will be afforded an opportunity to voice and identify what training they feel is needed to successfully work with the young people going forward, if external training is needed then this will be sourced. This will be in person training rather than online training to ensure effective understanding.<br>The Clinical and Positive Behaviour Support Department will be utilised to assist centre management in assessing specific training requirements | Regional Manager governance support will provide an additional layer of oversight to ensure that all training is effective and that this is reflected in practice. |
| | Centre management must conduct a training needs analysis specific to the staff team in this centre and devise a programme of training and development based on the outcome of that assessment. A regular training needs analysis must be undertaken going forward. | The centre manager will ensure the training needs for the staff team is reviewed and that required training will be delivered to the staff team.<br>As part of the service governance report each month centre management will conduct a training needs assessment. This will ensure that there is ongoing of training needs. | As part of the service governance report each month centre management will conduct a training needs assessment. This will ensure that there is ongoing assessment of training needs. |