An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 130

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**24 Hr Care Services Residential Division**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**23rd, 24th & 25th November 2021**
Registration Status:	**Registered from 14th August 2020 to 14th August 2023**
Inspection Team:	**Sinead Tierney** **Lorna Wogan**
Date Report Issued:	**17th January 2022**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in August 2017. At the time of this inspection the centre was in its second registration and was in year one of the cycle. The centre was registered without attached conditions from the 14th of August 2020 to the 14th of August 2023.

The centre's purpose was to accommodate four young people of both genders from age thirteen to seventeen years on admission. The model of care was relationship based that enabled young people to participate to their full potential in environments, carefully planned to serve individual needs. It aimed to promote positive outcomes through education and building positive family connections. There were three 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
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 10th of December 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 22nd of December 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: 130 without attached conditions from the 14th of August 2020 to the 14th of August 2023 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, three young people were living in the centre. Staff interviewed and records reviewed by inspectors demonstrated that all young people were receiving care and support based on their individual needs. A child centred environment had been established that promoted the inclusion of young people in decisions affecting them. Inspectors spoke with all three young people who expressed their satisfaction with the care provided and spoke of warm, positive and trusting relationships with staff members. All allocated social workers interviewed by inspectors were satisfied with the quality of care provided and felt each young person's individual needs were being met.

Young people spoke of being supported in preparation for their child in care review (CICR) meetings and either chose to attend or were updated following the meeting. CICR reports were developed by the centre manager in conjunction with the staff team that further informed the review meetings. One young person was recently admitted to the centre and their initial CICR was undertaken in line with the requirements of the regulations. A second young person had an up-to-date care plan on file. The third young person had lived in the centre for 18 months and although CICR meetings had been held, there were no care plans on file. In the absence of the care plan, planning was informed through the staff members and young person's participation in the CICR meetings and ongoing consultation with key partners in the young person's life. There were numerous attempts on record from the social care manager endeavouring to obtain these plans however they were not received. Inspectors recommend that senior managers within the organisation escalate such matters to the principal social worker to ensure care plans are on file.

The placement planning process was informed by a recently updated centre policy. All young people had up to date placement plans on file with evidence of fortnightly review by team members. Plans were detailed and contained individual, tangible and achievable goals relevant to the needs of each young person. There was evidence of consultation with all key people relevant to the young person. Young people

informed inspectors that they were fully involved in decision making relevant to their care and felt listened to, supported and advocated for.

The centre had several other planning documents and systems in place that supported the placement planning process. These additional plans and regular planning meetings demonstrated an in-depth understanding of the needs and behaviours of each young person and interventions in place to support them.

Inspectors found that a wide range of keyworking and individual work was completed with young people. This work was related both to identified goals and opportunity led work. Records evidenced an emphasis on building trusting relationships with young people and encouraging them to make healthy choices and positive life decisions.

There was a strong focus within the centre on supporting young people to maintain their family connections and on staff building relationships with family members. One young person who spoke with inspectors identified how meaningful this support was to them and their family. Records demonstrated that families were updated regularly on the progress of the young person and invited to be involved in planning for their care.

All young people availed of specialist supports and were supported by the staff team to engage with these services. Efforts were made to ensure that additional supports and assessments that may benefit the young people were incorporated into planning meetings. The organisation had an in-house psychologist who supported and guided the staff team to meet the needs of the young people.

Communication structures were in place between the centre, the allocated social workers, Guardians ad litem and other key partners regarding the care of young people. All social workers spoke of effective communication with the centre and records evidenced that timely reports were sent to all parties following updates to placement plans and significant events in the lives of the young people.

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

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

Actions required

- None required

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 centre manager was the named person in charge and had been in post for three years. They had extensive experience working within children's residential centres and demonstrated effective leadership skills and qualities. Both young people and staff interviewed expressed their confidence in the manager and they had established a supportive environment within the centre. Social workers interviewed described the manager as having a good sense of young people's wellbeing and were professional in their approach. There was a service level agreement in place with the Child and Family Agency and meetings took place as required.

There were clearly defined governance arrangements and structures in place. The acting service manager had been in post three months and was responsible alongside the company director for the oversight of practice throughout the organisation.

All staff interviewed were clear on their roles and responsibilities. Governance arrangements included regular visits to the centre by the service manager and

director. Weekly internal management meetings, weekly manager reports, monthly managers meeting, quarterly senior manager meetings and quarterly significant event review group meetings were also in place. A review of a sample of these governance reports and meetings evidenced a strong focus on the care of young people and a value driven culture of learning and safety. A serious incident had taken place within the centre and a review of associated reports showed that an effective post crisis response plan had been put in place.

There was an internal management structure appropriate to the size and purpose of the centre. The manager was supported with their leadership responsibilities by a deputy manager and three social care leaders. All staff in these roles were appropriately qualified and experienced. The deputy manager was interviewed by inspectors and exhibited an in-depth understanding of the needs of young people and their role in supporting and developing the staff team. There was an appropriate delegation record in place that guided the deputy manager and social care leaders in their roles.

The centre's policy and procedure document had been updated in August 2021 with evidence of ongoing discussion at team meetings, management, and senior management meetings. A review of policies relevant to the inspectors found they were reflective of practice within the centre and took account of national standards and legislative requirements.

The centre had a quality assurance, governance and auditing policy in place. Internal self-auditing systems were focused on young people's care files and staff personnel files. The external auditing of the centre was the responsibility of the service manager. Audits relevant to themes 3, 5, 6 and 7 of the National Standards for Children's Residential Centres, 2018 (HIQA) were conducted in June and October 2021. On review of these audits, inspectors found the latter report to be qualitative in focus and contained a detailed action plan. An audit was also completed on the quality of data relevant to risk assessments, handovers, complaints, centre registers and meetings.

Whilst the inspectors recognise that efforts were made this year to complete external audits, the practice had not been fully embedded to date in line with the centre's policy. The registered provider must ensure that the centre's quality assurance, governance and auditing policy is adhered to and external audits are embedded as part of the centre's culture.

The centre had a policy led risk management framework in place that consisted of a draft organisational risk register, a centre risk register, an identification, assessment, and management of risks (IAMR) document for each young person alongside other relevant risk assessment documents. On review of the risk management framework, inspectors acknowledged that the management team had made efforts to develop it however further improvements were required to embed risk management within practice. The centre risk register was a universal register that was duplicated throughout the organisation. It did not reflect potential or actual risks associated with the centre and its operation and function was not fully understood by staff and management interviewed. The service manager in conjunction with centre manager must develop a centre specific risk register and build in monitoring and review processes.

Inspectors found that the IAMR document contained risks not relevant to young people and was generic by design. Identified high risks for young people were not prioritised within the document and irrelevant data was recorded. The centre manager must review the identification, assessment, and management of risks (IAMR) document and ensure that only relevant data is recorded, and risks are prioritised within the document. The centre's risk management policy should be updated to reflect the ongoing development of the risk management framework.

Inspectors recognised that prior to this final report being issued, the centre management was proactive and amended the IAMR and risk register to reflect potential and actual risks for young people and the centre.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

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

Actions required

- The registered provider must ensure that the centre's quality assurance, governance and auditing policy is adhered to and external audits are embedded as part of the centre's culture.
- The service manager in conjunction with the centre manager must develop a centre specific risk register and build in monitoring and review processes.
- The centre manager must review the identification, assessment, and management of risks (IAMR) document and ensure that only relevant data is recorded and risks are prioritised within the document.

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.

In ensuring that safe and effective care was delivered, there was ample evidence of ongoing workforce planning. This planning was supported by policies related to recruitment, retention, induction, supervision and learning and development. Management and senior management meeting minutes demonstrated ongoing discussion and decision making in planning and managing the workforce.

The centre had sufficient numbers of staff to meet the needs of young people. Staff were experienced and demonstrated collaborative practice and autonomy within their reports, supervision and team meeting discussions. Social workers described how staff responded appropriately to the young people and were supportive in their approach. There was a focus of ongoing learning and development and the majority of staff had completed both mandatory training and additional trainings. Where mandatory training had not been completed, future dates for this training were scheduled.

On review of the qualifications of staff it was found that three long term members of staff did not hold a social care or relevant qualification. These staff members were in post prior to the staffing qualifications requirements issued by the alternative care inspection and monitoring service. In line with the requirements these staff members should be supported to gain a qualification in social care or a related and relevant field.

On review of a sample of personnel files, inspectors found that all relevant documentation was on file including up to date Garda Vetting forms, references, and copies of qualifications.

Supervision records supported the established culture of child-centred care and were found to be reflective of the needs of young people and the support, development and accountability of staff. Supervision generally took place in line with the centres policy and inspectors recommend that the service manager continues to monitor the practice of supervision to ensure the centre policy is adhered to.

The centre had arrangements in place to promote staff retention and were in the process of strengthening these initiatives as part of the workforce development plan. A policy led on-call system that included procedures for on-call at evenings and weekends was in place.

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

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

Actions required

- The centre manager must ensure that all outstanding mandatory training is planned for and completed in a timely manner.
- The registered provider must ensure that development plans are in place for unqualified staff to gain a qualification in social care or a related and relevant field.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider must ensure that the centre's quality assurance, governance and auditing policy is adhered to, and external audits are embedded as part of the centre's culture.	The acting service manager has developed a schedule of audits for 2022 and had a focused conversation with managers through the monthly managers meetings to highlight the importance of same. The acting service manager has advised that there will be a mix of announced and unannounced audits. Ongoing	The company director will ensure that all announced and unannounced audits are completed and reported to the company director on a quarterly basis with the action plan completed. Any shortfalls will be recorded and managed.
	The service manager in conjunction with the centre manager must develop a centre specific risk register and build in monitoring and review processes.	This has been a huge learning curve and both the centre manager and acting service manager have amended this document to adequately reflect specific, current risks in the centre. We are currently reviewing this with the senior management team following further feedback from the lead inspector.	Risk, to include all elements will be discussed quarterly at senior management level and reviewed regularly as part of audit and governance processes. Any corrective measures will be put in place.

	The centre manager must review the identification, assessment, and management of risks (IAMR) document and ensure that only relevant data is recorded, and risks are prioritised within the document.	This document has evolved over time and this latest recommendation is most welcome. We have reviewed one young person's IAMR for further feedback and are now implementing all of the recommendations across the board. The acting service manager has discussed this with managers.	Learnings from this will be brought to the monthly managers meeting in January 2022. IAMR's will have ongoing review as part of the case management and auditing processes.
6	The centre manager must ensure that all outstanding mandatory training is planned for and completed in a timely manner.	The acting service manager (ASM) has scheduled dates for outstanding training in January 2022. A training schedule has been identified for the rest of the year. The ASM has developed a self-audit tool in personnel files to support managers in identifying training needs in a timely manner. While we discuss training at every monthly manager's meeting the ASM will ensure to focus on mandatory training needs to ensure all staff receive this training in a timely manner.	The acting service manager will complete a yearly review of training to ensure that dates are identified at the beginning of the year to respond to service needs. All measures will be undertaken to ensure that if a staff member cannot attend an identified date that they will be rescheduled as soon as possible.

	The registered provider must ensure that development plans are in place for unqualified staff to gain a qualification in social care or a related and relevant field.	Through supervision one staff member has identified a plan to progress their development and gain a social care qualification. The other two staff members will be provided with every opportunity to support their professional development within social care or a relevant field and need for same outlined.	This will continue to be addressed through supervision on an ongoing basis.