An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 170

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Galtee Clinic**
Registered Capacity:	**One young person**
Type of Inspection:	**Announced Themed Inspection**
Date of Inspection:	**19th, 20th and 21st April 2021**
Registration Status:	**Registered from the 15th March 2021 to the 15th March 2024**
Inspection Team:	**Anne McEvoy** **Lorna Wogan**
Date Report Issued:	**23rd July 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 monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration on the 10th April 2020. The certificate of registration was initially issued as a special arrangement for one named young person for a specified timeframe. The centre applied for full registration in March 2021 and at the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions.

The centre's purpose and function was to accommodate one young person. The services offered by the centre were based on a social pedagogy model and trauma and attachment theory. The centre was operating a hybrid model of social pedagogy and more traditional residential care specifically constructed and tailored to meet the needs of the child placed in the centre. The centre used social pedagogical practice, the promotion of activity therapies and relied heavily on the young person having attachment figures in their life. 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
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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 via teleconference with the relevant persons including senior management and staff, the allocated social worker team leader and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those

concerned with this centre and thank the young person, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 23rd June 2021 and to the relevant social work departments on the 23rd June 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 07th July 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: 170 without attached conditions from the 15th March 2021 to the 15th March 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5 Care Practices and Operational Policies
Regulations 6 (1) and (2) Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 - The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, national policies and standards to protect and promote the care and welfare of each child.

Inspectors found that since the previous inspection, in October 2020, centre management and the registered provider had reviewed and updated the suite of policies and procedures being used. At the time of inspection, this process was still on-going with the majority completed. Inspectors were provided with the up to date policies and procedures currently in place and found these to be in line with the National Standards for Children's Residential Centres, 2018 (HIQA). Upon review of these documents, they demonstrated how legislation impacted on their practice and addressed gaps in compliance. A timeframe for the completion of the policy update was provided to inspectors and records of quality improvement days reviewed by inspectors demonstrated significant and on-going work on this issue.

Staff had received training in the National Standards for Children's Residential Centres 2018 (HIQA) and existing legislation such as Children First and there was an on-going training programme in place to familiarise staff with new policies and procedures. There was also evidence that policies and procedures were discussed at team meetings and with staff in supervision. In interview, staff demonstrated an understanding of the relevant legislation, regulations, policies and standards for the care and welfare of children in residential care and inspectors found that this was reflected in their practice.

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-centre, safe and effective care and support.

Inspectors found that leadership was demonstrated and evidenced in the residential centre and a review of centre records such as team meetings, significant event review

meetings and handover records demonstrated a culture of learning, quality and safety. There was a designated centre manager in place at the time of inspection. The centre manager held an appropriate qualification for the post and though this was their first time in a management position, staff members and senior management expressed confidence in their leadership abilities.

Inspectors found that while the centre had developed a system of oversight from centre manager to service director, the lines of communication from service director to clinical director were not sufficiently robust and the centre lacked a structured system for organisational oversight from the clinical director. Inspectors found that there was little impact on the care of the young people but the informal system of governance needed to be more robust. The service manager and clinical director must ensure that an appropriate system is implemented with immediate effect.

There were clearly defined roles and responsibilities in the centre's statement of purpose and function and in interview staff were knowledgeable about their role within the centre. While staff members did not recall being provided with a job description, copies of job descriptions were available on a sample of staff personnel files that were examined. Staff members interviewed were clearly able to outline their role and expectations of them in their positions. Inspectors recommend that job descriptions be recirculated to ensure that staff have access to their own copy of their job description.

There was a service level agreement in place with TUSLA, Child and Family Agency and regular meetings took place with the organisation's clinical director. It was confirmed to inspectors that the service provided regular reports to the funding authority.

In interview staff were aware of the lines of authority and accountability. Inspectors found evidence to support that the service manager provided information to the board and sought feedback from them to progress the work of the centre. It was noted in the last inspection report of October 2020 that there was little evidence that matters brought to the attention of the board of management were responded to in a timely manner. This inspection again found that this had not been adequately addressed. There was no record of a formal board meeting since the last inspection. The registered provider must ensure that a formal structure to the operation of the board is resumed in line with their written protocols to facilitate formal strategic planning.

There was evidence on records that the service manager had regular oversight of centre documents, and in interview with the young person and staff, they confirmed that the service manager had met with them on visits to the centre.

The service manager was identified as the person in charge with overall executive accountability, responsibility and authority for the delivery of the service. They were supported in this role by the centre manager. Inspectors found that they provided effective oversight to the care practice in the centre, through regular communication, management meetings and through a review and oversight of practices and paperwork.

Inspectors found that the centre had developed a comprehensive risk management policy and there was a risk management system in place. The organisational risk register contained all relevant risks and control measures which were rated and then re-rated following the implementation of control measures. Inspectors were satisfied that the risks associated with the young people were comprehensively risk rated and managed. Environmental risks were also identified along with the control measures in place. There was evidence of oversight of risk by senior management in monthly meetings, audits and their visits to the centre. In interview and in questionnaires staff were familiar with the risk register and risks identified on that register and strategies in place for managing this risk. Inspectors saw evidence of the risk register and associated risks being discussed in team meetings and in supervision.

Since the last inspection, the centre had implemented a data protection policy and was found to be operating in line with this policy.

The centre had a management structure appropriate to its size and purpose and function. There were arrangements in place to provide adequate managerial cover when the manager took periods of leave. There was evidence of a written task list to assign duties to staff members in the centre.

There was an on- call policy in place to assist staff in dealing with any crises or emergencies that arose. In interview staff confirmed that the on- call system was functional and suitable for the task.

The Covid-19 pandemic and issues of risk infection were managed well within the centre. The risks associated with Covid-19 were included on the risk register. The centre had a Covid-19 risk management document, and this was updated regularly. There was a contingency plan in place to draw staff from the relief panel if staff were

confirmed or suspected of having Covid-19. Inspectors recommend that this contingency plan is incorporated into the risk register. Staff reported they felt safe in their work environment and had adequate access to personal protective equipment. Inspectors found that as restrictions were eased the centre realigned their risk assessments in line with guidance and advice from the National Public Health Emergency Team and government guidelines.

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

The centre's statement of purpose had been developed upon registration of the centre and was compliant with the standard. Inspectors found that it clearly described the model of service provision delivered by the centre in line with regulatory requirements as outlined in the National Standards for Children's Residential Centres, 2018 (HIQA).

The statement of purpose was reflected in the day-to-day operation of the centre. It included the aims, objectives and ethos of the service and detailed the organisational structure describing the management and staff employed in the centre. There was a child friendly version of the statement of purpose and there was evidence that this had been explained to the young person in the centre. In interview the young person articulated they understood what the centre was about and what it would provide for them. A copy of the statement of purpose had been provided to the referring social work department at the time of admission and upon request the guardian ad litem confirmed that they were provided with a copy. There were systems in place to review this document.

Inspectors found that staff had a comprehensive understanding of the model of care utilised in the centre. Staff confirmed that they had received training in the model of care and inspectors viewed certificates issued on foot of this training. The centre had also employed a new staff member, qualified in social pedagogy, whose role it was to role model and fully embed the social pedagogy principles of living, in the daily care practices of the centre. This was complimented by formal in- house training on the model of care.

The social work team leader allocated to the resident young person stated that they were satisfied with the quality of care provided to the young person and the progress they had made in their placement using the current model of care. The guardian ad litem stated that the young person's needs were adequately addressed and met within

the centre and was satisfied that the centre was open to external consultation regarding the model of care and its implementation.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Since the last inspection in October 2020, the centre had clear and well developed systems in place to monitor, improve and evaluate the quality, safety and continuity of care provided to the young person. Inspectors found clear auditing processes in place which were aligned to the National Standards for Children's Residential Centres 2018 (HIQA). Inspectors recommend that both the centre manager and service manager utilise the comment sections of these audits more to reflect a qualitative analysis as well as a statistical analysis of information recorded. Inspectors found that there were detailed records held of handover meetings and team meetings but there was little evidence of staff having signed these documents to evidence that they have read and understood the documents. The centre manager and service manager must ensure that staff review and sign centre records to demonstrate that they have read and reviewed the documents. Similarly, management must ensure that registers are signed to evidence that they have been reviewed.

There was evidence of management conducting quality improvement days and these days were used to address gaps in service provision such as updating policies and procedures to improve the quality and safety of care provided to the resident young person. There was evidence the centre manager monitored the quality of care in the centre through oversight of all records, observation of staff practice and contact with the young person.

The centre had a complaints policy in place that was understood by both staff and the young person. The young person was aware of their right to complain and how to make a complaint. The young person had no current concerns about their care. Inspectors found that complaints were recorded, managed, reviewed and investigated in a timely manner. Inspectors found evidence of complaints being discussed at team meetings and changes occurring following this. Inspectors reviewed the minutes of significant event review meetings and found that these meetings aimed to identify trends and learning for the staff team. The learning from these meetings was communicated to all staff through the forum of team meetings and supervision. This was confirmed by a review of team meeting minutes and by staff in interview.

The service manager was aware of the requirement for the registered provider to conduct an annual review of compliance and inspectors were advised that efforts were being made to ensure completion of this document on an annual basis. The quarterly reports by the service manager were being used to form the basis of this report.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.1** **Regulation 6.2**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 5.1** **Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.2** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The registered provider must ensure that an appropriate system for organisational oversight is implemented with immediate effect.
- The registered provider must ensure that a formal structure to the operation of the board is resumed to facilitate formal strategic planning.
- The centre manager and service manager must ensure that staff review and sign centre records to demonstrate that they have read and reviewed the documents. Similarly, management must ensure that registers are signed to evidence that they have been reviewed.

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 an appropriate system for organisational oversight is implemented with immediate effect.	Service Manager will provide Clinical director with a weekly governance report every Friday, submitted by email. Clinical director will provide oversight and feedback on that governance report, submitted to service manager by email. Clinical director will be forwarded all SERG's for review, attend all management meetings, Clinical management meetings. Audit reports will be shared with Clinical director also and Clinical director will provide oversight on all internal audits. Effective Immediately.	Senior Management meetings to be scheduled monthly, and Service Manager and Clinical Director to attend. Next Senior Management meeting to be scheduled in July 2021. Governance reports to be a standing agenda item on Senior management meetings.
	The registered provider must ensure that a formal structure to the operation of the board is resumed to facilitate formal strategic planning.	There are 2 board members in situ, and they are actively recruiting a third board member with the aim of the board members to be finalised by September	Operation of the board, frequency of board meetings and communication between service manager and the board to be discussed at next Senior Management Meeting scheduled for Friday 16th July

		2021. Board Meeting will be scheduled for late September 2021.	2021. This to be an agenda item at next Board Meeting scheduled for September 2021.
	The centre manager and service manager must ensure that staff review and sign centre records to demonstrate that they have read and reviewed the documents. Similarly management must ensure that registers are signed to evidence that they have been reviewed.	Centre records are emailed to all team members. Centre manager will print a copy of all centre records following each meeting and will leave a copy in the House for all team members to sign. Centre Manager will ensure the team sign all centre records when present in the House daily. Effective immediately.	Centre Manager present in House every morning and will ensure that all team members have read and signed all paperwork relating to that House. This will be added to monthly internal audits as a standing agenda item. Centre Manger will discuss the importance of all centre records being signed and dated by all team members at next team meeting scheduled for the 21.07.21.