An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Registration and Inspection Service

Children's Residential Centre

Centre ID number: 077

Year: 2016/ 2017

Lead inspector: Lorraine O' Brien

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Registration and Inspection Report

Inspection Year:	**2017**
Name of Organisation:	**Solis MMC**
Registered Capacity:	**Four young people**
Dates of Inspection:	**Announced visit: 20th of October 2016.** **Unannounced visit: 27th of October 2016.** **Follow up visit: 10th of March 2017.**
Registration Status:	**Registered without conditions from the 18th of July 2016 to the 18th of July 2019**
Inspection Team:	**Ms. Noreen Bourke** **Ms. Lorraine O' Brien**
Date Report Issued:	**July 2017**

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1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)). The Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Methodology

The centre was granted their first registration in 2013 to accommodate four children of both genders from age thirteen to seventeen years on admission on a medium to long term basis. The registration expired in July 2016 following which the centre was granted a second three year cycle.

A Child and Family Agency inspector carried out an introductory visit to the centre on the 20th of October 2016. At that time the centre had recently moved premises, the centre manager also had recently changed and the two young people resident in the centre were newly admitted. The inspector met with the centre manager and young people during their visit and planned to carry out further visits when the staff and young people had time to settle in.

Shortly after the visit, a serious incident was reported to TUSLA Child and Family Agency that highlighted a number of concerns in relation to the ability of the centre to adequately provide care for one of the two young people. The registration and inspection service for children's residential centres assessed from the information provided that there was cause for concern and that further assessment was required. In response a TUSLA Child and Family Agency inspector carried out an unannounced visit to the centre on the 27th of October to specifically ascertain the centre's compliance with specific standards and to establish if there was validity to the concerns raised. A number of issues requiring action were identified. A time span of five months was granted to the centre for them to put strategies in place to address the issues identifying action.

A follow up visit was carried out on the 10th of March 2017 and the inspectors found that the centre made significant progress to increase the quality of service being provided by the organisation. The findings of the follow up visit were presented to the registration panel and it was decided to continue to register the centre without conditions.

The first visit was announced, the second visit was unannounced and the follow up visit was announced.

This inspection report sets out the findings of inspections carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the ongoing operation of the centre in line with its registration. The report is based on a range of inspection techniques including:

- An examination of one young person's referral information.

- An examination of documentation provided by the centre manager in relation to a serious incident in the centre.

- An inspection of the premises and young person's bedroom.

- An examination of the centre's significant event notification report, a daily log and waking night record.

- A review of previous placement information.

- Site view of one young person's bedroom.

- Discussions with relevant persons that were deemed by the inspector as to having a bona fida interest in the operation of the centre including but not exclusively :

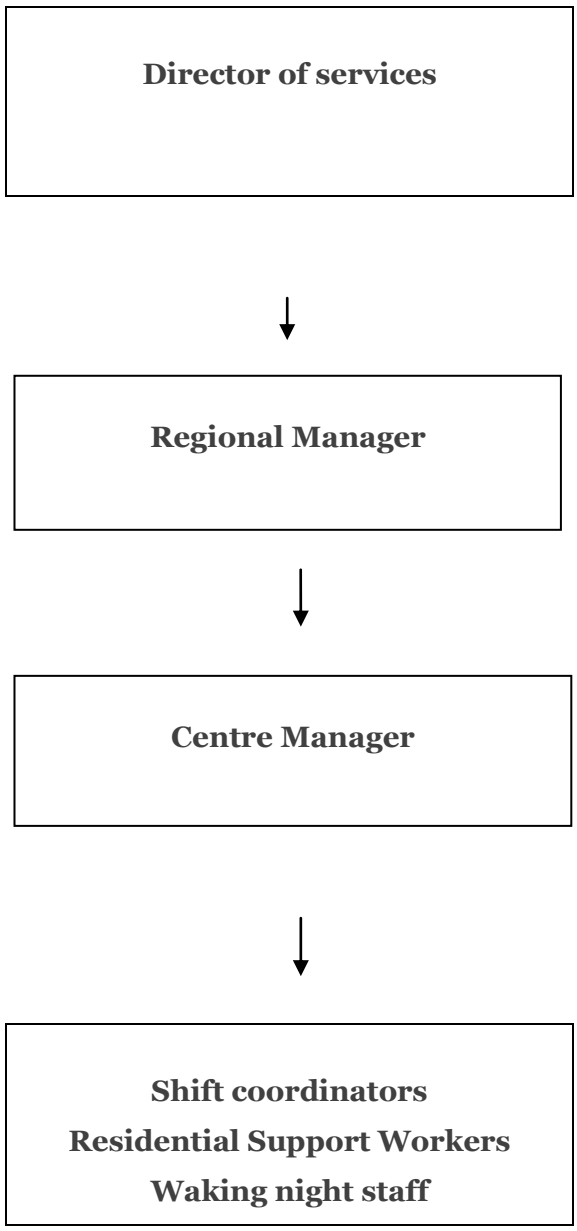
- The centre manager
- The young person's social work team leader
- The TUSLA Child and Family Agency Placement Committee

- Observations of care practice routines and the staff/young person's interactions.

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.

1.2 Organisational Structure



2. Findings with regard to registration matters

A Child and Family Agency inspector carried out an introductory visit to the centre on the 20th of October 2016. Shortly after the visit, a serious incident was reported to TUSLA Child and Family Agency highlighting a number of concerns. In response an inspector carried out an unannounced visit to the centre on the 27th of October to specifically ascertain the centre's compliance with specific standards and to establish if there was validity to the concerns raised. A number of issues requiring action were identified. Through consultation with the service the inspectors found that the service embraced the findings and gave a commitment to put strategies in place to address the issues identified. A time span of five months was granted to the centre following which a follow up visit was carried out on the 10th of March 2017. The inspectors found evidence that the centre made significant progress to increase the quality of care being provided by the organisation.

The findings of this report and assessment of the submitted action plan deem the centre to continue to operate in adherence to regulatory frameworks, the National Standards for Children's Residential Centres (2001) and in line with its registration.

As such the registration of this centre remains registered without conditions from the 18th of July 2016 to the 18th of July 2019.

3. Analysis of Findings

3.4 Children's Rights

Standard
The rights of the Young People are reflected in all centre policies and care practices. Young People and their parents are informed of their rights by supervising social workers and centre staff.

3.4.1 Practices that met the required standard in full
None identified.

3.4.2 Practices that met the required standard in some respect only

Consultation

The inspector carried out a visit to the centre on the 20th of October 2016 for the purpose of meeting with two young people recently admitted to the centre. Prior to this the inspector had telephone contact on the 27th of September with the centre manager is respect of the young people admitted. The centre manager reported one of the young people had spent the previous weekend at the centre and was settling in well. The second young person was also in the process of settling in the centre. Their placement was a shared arrangement with their parent and the arrangement was clearly understood by the young person, their parent, social worker and the centre.

The inspector met with one young person's social worker on the 12th of October who reported that the young person was doing well in the placement. The shared arrangement between the centre and home was going well.

In the course of the visit the inspector did a brief review of the care file of one of the young people. The objectives of their placement were outlined clearly in the records, reports and plans.

The inspector noted in reviewing a report from one of the young person's previous care placements that the issue of their personal hygiene was assessed as being extremely poor and that this had to be addressed with the young person on several occasions. This was done through different prompting and specific individual work with the young person before they attended to their hygiene needs.

The inspector met with the two young people in placement. On arrival at the centre both young people were engaged with staff, one young person was cooking and the second young person was playing a computer game. There was a pleasant atmosphere in the house and the activity with the young people was centered in the kitchen area. As it was close to Halloween one young person was excited about Halloween; played tricks on the inspector and dressed up in their Halloween costume.

One young person told the inspector that living in the centre was OK, but would prefer to be living closer to home. They stated that they met their social worker in the centre and was of the understanding that they would be returning to live closer to home if a placement could be found for them. The young person knew who their assigned key workers were and spoke about family access and said that they would like to have more access with their family.

The inspector requested to see the bedrooms of both young people. One young person's bedroom was in a reasonable state of cleanliness. On visiting the bedroom of the second young person the inspector was concerned at the unkempt and unhygienic state it was in. The room and bed were so cluttered it left only a small space on a double bed for the young person to sleep in.

The centre manager stated that they had not viewed the young person bedroom and this was done to respect the privacy of the young person. The inspector found that no member of staff had reported to the centre manager that the living condition of the young person was unacceptable. Given the complexity of needs that the young person presented and the availability of prior reports to indicate that this young person required intensive support regarding personal care, the centre failed to meet the needs of this young person under Standard 6.6.4. The inspector immediately forwarded a copy of guidance on intimate care for young people and informed the centre manager, the director of the organization and the placing social worker regard the findings of the visit.

The inspector also met with the other young person individually. They said that they liked living in the centre and liked the idea of being able to go home at weekends. They were able to identify staff within the centre who were their key workers and spoke about work that had done with them, these included day trips which were of an educational and historical nature.

Neither young person were in education but given that they both had only recently been admitted to the centre, educational placements were being sourced for them by the care staff. As they were not in school there was an expectation by the centre that they participate in some kind of activity during the day.

Complaints

Complaints criteria were not reviewed as part of this inspection.

Access to information

Access to information criteria was not reviewed as part of this inspection.

3.4.3 Practices that did not meet the required standard

None identified.

3.4.4 Regulation Based Requirements

The Child and Family Agency met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995, Part II, Article 4, Consultation with Young People.***

Required action

- The staff team must support the young person to maintain their individual space to an acceptable standard.

3.7 Safeguarding and Child Protection

Standard
Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

3.7.1 Practices that met the required standard in full

None identified.

3.7.2 Practices that met the required standard in some respect only

Following the serious incident reported to TUSLA Child and Family Agency a number of concerns were raised in relation to the ability of the centre to adequately provide care for one young person. The inspection service liaised with the inspector and both agreed that in response to the notification a TUSLA Child and Family Agency inspector should carry out an unannounced visit to the centre. The visit took place on the 27th of October with the purpose of specifically ascertaining the centre's compliance with specific standards and to establish if there was validity to the concerns raised. The inspector found evidence to support the finding that there was validity to the concerns as the external management team's systems were not sufficiently robust in order for appropriate and suitable care practices and operational procedures to be maintained. The inspector concluded that a robust structure needed to be put in place that would adequately provide external oversight of the service and take action with strategic plans when issues present themselves in order to avoid compromising the quality of care the young people received and the safety and welfare of the staff team.

The inspector found evidence that despite a significant amount of background information available prior to one young person's admission about the potential risks surrounding the management of them, there appeared to be a low level response and inadequate safeguards in place to care for the young person. The night staff on duty in the centre were unqualified and lacked social care experience which can caused a lack of insight into the young people's needs that a more stable team would provide and this had direct implications on the level and seriousness of the incident that occurred in the centre. The inspector found that young people in the centre had an increased level of vulnerability and risk to others due to their complex set of needs. The inspector raised their concerns in relation to the lack of experience and qualifications of the waking night staff during the inspection to the centre manager, and the regional manager, an issue that needed urgent attention.

From experience and a review of relevant research the inspector concluded that working with young people with complex needs required a highly skilled, experienced and stable staff team. The inspector voiced their concern to the centre manager and the young people's social worker in relation to the sustainability of safeguarding practices in the centre at the time of the inspection as a result of the lack of oversight to ensure all safeguarding systems were in place. The management and staff team failed to constantly apply strategies and interventions to avoid episodes of absences. The inspector found that the centre had CCTV cameras located on the exterior walls of the house. The inspector discussed the use of the CCTV with the centre manager and was informed that the CCTV cameras were not recording and nobody was

checking to ensure that they were working effectively. This evidenced the fact that the system was not being routinely checked to ensure it was in good working order.

The inspector found clear evidence from pre-admission social work records that the young person had complex and individual needs which required specialised and experienced carers in order to prevent serious incidents and future placement breakdowns. The social worker stated it was important that any future placement was secure enough that the child does not encounter further disruption and placement breakdown in their life. The inspector questioned if the staff team were receiving adequate ongoing specialist training in order to support them to meet the emotional needs of the young people.

The day staff had a recognised social care qualification or equivalent, however the waking night staff did not. The inspector raised their concerns in relation to the lack of experience and qualifications of the waking night staff during the inspection to the centre manager, and the regional manager especially given the high level of vulnerability of the young people in the centre. There was no evidence that strategies such as increased supervision sessions, increased support and oversight of practice through the allocation of a mentor were put in place.

The inspector again during this visit viewed one young person's bedroom and found that they were unnecessarily untidy and in a state of chaos. To enhance young people's ability and skill to be able to live independently and as part of a group the staff team must support them to maintain their individual space to an acceptable standard. The inspector was particularly concerned in relation to this issue being unresolved as it has also recently been highlighted by another the TUSLA Child and Family inspector. The staff team must support the young person to maintain their individual space to an acceptable standard.

Child Protection

The child protection criteria was not reviewed as part of this inspection.

3.7.3 Practices that did not meet the required standard

None identified.

Required Action

- The centre manager and regional manager must review their safeguarding practices to ensure they are constantly kept to an appropriate standard.

- The placing social work department must provide the inspection service with a copy of their review finding of the recent serious incident.

- The senior management team must conduct a full review of their governance practices in order to inform themselves of the reasons for the serious incident occurring and put strategies in place to rectify all deficits in their system.

- A robust structure must be put in place that adequately provides external oversight of the service and takes action with strategic plans when serious issues present themselves in order to avoid compromising the quality of care the young people receive and the safety and welfare of the staff team.

- The centre must have a policy in place in relation to the maintenance and control of CCTV cameras in accordance with the Data Protection Act 2003.

4. Action Plan

Standard	Issues Requiring Action	Response	Corrective and Preventative Strategies To Ensure Issues Do Not Arise Again
3.4	The staff team must support the young person to maintain their individual space to an acceptable standard.	The centre manager and staff now regularly check the young people's bedrooms and independent skills are built into the young people's daily plans.	Evidence of support for the young person to maintain their space is being further enhanced by the service and reviewed by management.
3.7	The centre manager and regional manager must review their safeguarding practices to ensure they are constantly kept to an appropriate standard. The placing social work department must provide the inspection service with a copy of their review finding of the recent serious	Following the incident, a review of the centre's purpose and function is under way. No further admissions to the centre have taken place until this review is concluded.	All future referrals to the centre will be screened for behaviours and histories which may place the young person, staff teams and wider community at risk. In particular, the view of Consultant Psychologist will be sought where such risks are identified. A comprehensive discussion and agreement of PSP's and ICMP's outlining supervision levels, monitoring and placement safeguarding expectations must be in place prior to admission. The inspection service liaised with the placing social work department and verbally received a synopsis of their review findings. The

	incident.		inspection service have requested a written copy and will follow up with the social work department to ensure it is provided.
	The senior management team must conduct a full review of their governance practices in order to inform themselves of the reasons for the serious incident occurring and put strategies in place to rectify all deficits in their system.	Management engaged the local Garda Crime Prevention Officer who has since reviewed and compiled a report detailing recommendations for the centre and monitoring systems. This is currently being progressed by the security firm with responsibility for the CCTV oversight.	The Organisation has since appointed a full time Regional Quality Assurance Officer. An audit has taken place with identified actions. Both announced and unannounced audits will be a feature. Audits took place on the 19th May and 8th November 2016. The inspectors interviewed the Regional Quality Assurance Officer during their follow up visit in March 2017 and found that they had clear systems in place to monitor the quality of service being provided in the centre.
		Live night monitoring procedures for young people have also been amended. However, physical checks must be authorised by the relevant social work teams. External oversight can be evidenced by the immediate strategic planning by the Regional Manager and Director following the incident. This included advocacy for the young person whilst in custody, consultation with senior	During the follow up visit in March 2017 the inspectors found that two unqualified live night staff were part of the staff team. The inspectors liaised with the centre manager and this arrangement was ceased. The inspectors will continue to monitor that all core staff members are qualified, staff in training are surplus to the staff team and that no unqualified person who is not in training will be recruited.

		TUSLA management, Gardaí and social work regarding alternative placement. Due cognisance is paid to the support for the staff team and external staff care services are readily available. Team Meetings and incident debriefs are a feature. A review of all placements is held on discharge with the staff team and incident was reviewed by the Regional SEN Review Panel chaired by the organisation's TCI Trainer.	
	A robust structure must be put in place that adequately provides external oversight of the service and takes action with strategic plans when serious issues present themselves in order to avoid compromising the quality of care the young people receive and the safety and welfare of the staff team.	Internal governance reports were initiated in 2016 and form the basis of supervision with the ACM and Regional Manager. The Centre Manager will return to her post on a full time basis following maternity leave in February 2017.	The inspectors reviewed governance reports during their follow up visit and found them to be fit for purpose and an effective monitoring tool. The centre manager had returned to the centre at the time of the follow up visit.
	The centre should have a policy in place in relation to the maintenance and control of	A CCTV policy is in place. In regards to the maintenance and control, enhanced daily	A new CCTV system was installed on the day of the follow up inspection visit.

	CCTV cameras in accordance with the Data Protection Act 2003.	measures have been put in place to ensure that the system is fully functional.	Performance reviews with the shift team co-ordinators have taken place with particular emphasis on governance, responsibilities and accountability in regards to client key working. All performance will be intrinsically linked with audit outcomes, monitoring reports and SEN's.