An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 086

Year: 2024

Report on the review of an attached condition & CAPA implementation

Year:	2024
Name of Organisation:	Streetline CLG
Registered Capacity:	Four Young People
Type of Inspection Activity:	CAPA Review
Dates of inspection activity:	18th & 19th June 2024
Registration Status:	Registered from 31st May 2023 to 31st May 2026
Inspection Team:	Ciara Nangle Janice Ryan
Date Report Issued:	18th September 2024

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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 and Regulation 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. Centre Description

This inspection report sets out the findings of an inspection carried out to determine the implementation of the centre's Corrective and Preventative Actions (CAPA) following on from a Themed Inspection carried out in November 2023. This findings of this CAPA Review inspection 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 May 2002. At the time of this inspection the centre was in its eight registration and was in year two of the cycle. Following the inspection in November 2023 the centre had a condition attached, the condition being that;

1. All staff have completed certified training in fire safety, evacuation and other procedures to be followed in the event of a fire.
2. All staff have completed certified training in first aid.
3. For staff who have lived in a state other than Ireland for a period of longer than 6 consecutive months, vetting information in respect of the person must be obtained from the police authorities in that state.
4. Evidence that the internal quality audit procedures had commenced.

The centre was registered as a multi-occupancy service for up to a maximum of four young people on a medium to long term basis aged 13-17 years old. Their model of care was psychodynamic, humanistic and trauma informed, creating a safe and secure environment with everyday reparative opportunities for growth and development. There were two young people living in the centre at the time of this review inspection.

1.2 Methodology

The inspectors examined the progress made by the centre with the implementation of the CAPA from the previous inspection in November 2023. A blended inspection approach was utilised that involved an unannounced visit to the centre and a review of documents remotely. Interviews were conducted with centre management.

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 19th July 2024. The findings of the CAPA review was used to inform the registration decision.

The findings of this CAPA review and written submissions received by ACIMS in relation to the attached condition, has determined the centre to have implemented the required actions and therefore deem the centre to be operating 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: 086 without attached conditions from the 31st May 2023 to 31st May 2026 pursuant to Part VIII, and 1991 Child Care Act.

3. Review Findings

Regulation 5: Care Practices and Operational Policies
Regulation 7: Staffing
Regulation 9: Access Arrangements
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.5 Each child develops and maintains positive attachments and links with family, the community and other significant people in their lives.

Actions required:

- The centre management must ensure that an up to date young people's booklet is created that accurately represents how family, friends, hobbies and community are promoted and supported. The young people must be invited to contribute to it and be given a copy of it once updated.
- The centre management must ensure where a house policy is changed that it must be recorded as a restrictive practice and tracked until it can be removed.
- The centre management must review the placement plan content and key work recording to ensure that improvements are made and that levels of detail are consistently improved through a focused development plan.

Centre response:

- The young person's booklet has been discussed and reviewed at Team Meetings with the staff team. Young people in the house have discussed it with staff over the previous weeks and they are working with staff currently to implement suggested changes with additional details on significant people for the young person, hobbies, community engagement etc. The young people's booklet will be updated with amendments and young people's contributions by 02/02/2024.
- The restrictive practice form has been reviewed at team meetings with staff. A discussion on the restrictive policy in the house was held as well in line with our the model of care as the recommendations from ACIMS highlighted Dec 23 and Jan 24. The restrictive practice form is currently in the printers as of 15.01.2024 being incorporated into booklet form with columns for responsibility, the date a restrictive practice is recorded and should be removed. Restrictive practices will be discussed and overviewed as per event with SCM and/ or SDM. All restrictive practices were and will be reviewed and recorded at team meetings; effective immediately

(10.01.2024). Restrictive practices will be discussed and overviewed as per event with SCM and/or DSCM. An addendum will be added to include "Young People informed/consulted, if a SW needs to be informed and date of removal of RP"

- The placement plan will be updated monthly or more frequently as required with more detailed content added in line with the model of care. This will be completed by SCW staff, keyworkers and the centre management. Placement Plans will be discussed at team meetings, effective immediately with full review on last team meeting of each month.
- Re-introduction of clinical practice report template with discussion at each team meetings to reflect more detailed clinical content, key working observations, understanding of young person and "what has changed" has been reintroduced. This is to be more process led and goal-oriented to ensure continuous improvement; effective immediately as of 03.01.2024.

Review findings:

The young persons booklet was updated following the last inspection. The process included consultation with the young people who were resident in the centre and the staff team. A copy of the updated booklet was provided to inspectors during this review process. The booklet contains relevant information in relation to the centre. The centre manager advised in interview that this will be reviewed annually to ensure it contains up to date information relevant to the young people who may be moving to the centre. This will be done with the residents of the centre and the staff team. Inspectors saw evidence of this being discussed within team meetings. The centre manager advised that they hope to have a parents/guardians booklet completed by the end of the year and this is something they are currently working on.

The centre had implemented new forms for the recording of restrictive practices, and these were contained in a specific book that was prefilled with the forms. Each young person had their own book to record the restrictive practices in place. Within this form it detailed the issue causing the need for the restrictive practice to be put in place, the rationale, the risks, the people consulted, the details of the restriction and the rationale for these, the alternatives explored, when it will be reviewed and who signed it off. Risk assessments were also held on the young people's care records. Since the last inspection, three restrictive practices had been in place, they included limiting access to rooms and friends not being permitted in the centre for a period of time. They were reviewed and implemented in line with the National Standards for Children's Residential Centres, 2018 (HIQA). While it had been outlined in the centre's CAPA that an addendum to include consultations with social work/young people

and date of removal would be attached to the new form for recording restrictive practices, the centre found that in practice all required information could be recorded within the existing form and an addendum was not required.

Placement plans for both young people were reviewed. These included details of the action required, a description relating to it, person responsible and timeframe. Placement plans were aligned to the care plan and were in place for periods of three months. They were reviewed monthly at team meetings. Team meeting records did not include details of the discussions of the young people as the centre advised they had previously been informed that details should not be recorded in line with data protection practices. This limited inspectors' ability to track or ascertain the level of discussion that occurred in relation to placement planning or changes being made throughout the three-month period that the plans were in place for.

Within the placement plans, the description associated with the action was at times generic and did not specify the steps that should be taken to achieve the action identified. More specific detail in relation to this would be beneficial. Key workers prepared bimonthly key working reports which were presented to the team at team meetings. These included details in relation to all aspects of the young people's care, number of key work sessions completed, Significant Events, Family contacts, Child Protection Referrals amongst other relevant information. Clinical practice reports were attached to these key work reports following the team meeting discussion and they included brief details of discussion and actions agreed. The centre manager advised that these were discussed weekly at the team meetings, however inspectors did not find weekly clinical reports on file, and due to the limited detail in team meeting records could not ascertain if these were discussed weekly.

Regarding key working, inspectors reviewed a sample of records relating to both young people. Key work sessions were limited and appeared to be opportunity lead rather than preplanned. Individual contact forms also recorded individual work sessions with the young people, and while the topics covered within these aligned to the placement plans, the records presented them as opportunity lead, when the young person raised an issue or if the situation presented. In interview the centre manager advised that while they appear opportunity led, they tended to be preplanned during the team meetings, however due to the limited detail recorded inspectors could not review the planning that occurred in relation to this. The centre manager must ensure that team meeting minutes capture the agreed actions and key decisions made in relation to placement planning and key working.

The centre manager advised that they had identified key work planning themselves as an area that required further development and that they are in the process of introducing case planning meetings monthly with the social care leaders and key workers. These meetings will include the planning of topics to be covered in key working sessions and the planning around the completion of these. The centre were developing a form which will be used to guide these meetings and is due to commence in the coming months. Should these be implemented effectively it should allow for planning of more tailored and specific key working to be completed.

Further Action Required

- The centre manager must ensure that the actions outlined in the CAPA under this theme continue to be implemented into practice within the centre.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 7** **Regulation 9** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 1.5**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

Actions required:

- The centre management must put an audit mechanism in place and thereafter complete a full audit of the staff personnel files. An immediate plan must be put in place to address the deficits identified. The updated personnel and training files must be presented for inspection to the ACIMS by the end of January 2024.
- The registered proprietor and centre management must ensure that a record of all mandatory training completed is maintained.
- The centre management must ensure that the induction policy is implemented in a consistent manner for all staff, that the dedicated template is completed and filed to inform probations and ongoing planning for training and development.

Centre response:

- There has been a re-introduction of the personnel file audit system. A full audit of personnel files started in December 2023 and will be completed by 02/02/2024 with any deficits addressed.
- Once reviewed, the current staff personnel files will be considered audited (staff up to 31 Dec 2023). The only additions to 31 Dec 2023 files will be annual supervision / probation / appraisal schedules, sick notes/leaves, complaints/disciplinary, resignations and financial/holiday agreements. The latter will be reviewed with SCM and Governance Manager every month and discussion of same is included in the centre management (Governance Manager and SCM and/or DSCM) weekly meeting template.
- Since December 2023, the training folder (incorporating "Mandatory", "Centre-Mandatory" and other CPD) has been removed from each staff member's physical personnel file, and there is now one Training Folder Box in the staff room for all printed certs. The printed mandatory training certs are to match those on the individual staff digital training folder on the Staff Desktop. Training has already been given and will continue to be given in the individual Excel Training/CPD tracking audit system developed in December 2022, with each staff member having individual training excels tracking all CPD. The training folders (physical and digital) will be checked by social care management team weekly to ensure compliance and the digital file will be sent monthly for auditing by the Governance Manager; effective immediately. All staff currently up to date and/or booked into available limited places for TCI training Tusla Jan- March 2024. Training and the new system has been on the agenda and discussed at each team meeting with all staff to ensure all staff are up to date with training requirements. It is and will also continue to be part

of individual staff supervision with the social care manager and the deputy social care manager.

- The induction system has been modified so that induction is only deemed complete and to be filed by the governance manager in the physical personnel file once the new staff member and social care management have signed off on each section of the template including discussion of probation.
- The social care manager and deputy social care manager to inform governance manager when a staff member has completed all relevant sections of induction and/ or if any HR issues and to ensure within the first month all of the Induction checklist for new staff is complete and filled in induction box. Effective immediately from 01.01.2024
- Governance manager to check the mandatory training section of the training audit file. Effective immediately 10.01.2024

Review findings:

An audit of personnel files was completed by the centre supported by the governance manager. This audit was undertaken on a file when a new staff member commenced within the centre to ensure that their files were compliant with the requirements of the organisation. The deficits identified within personnel files during the inspection in November 2023 were addressed by the organisation and updates were provided to the inspectorate in January 2024 and April 2024. Documents that remained outstanding in April 2024 were now on file and inspectors reviewed these. Where employer references were identified in previous inspections as not having a date of completion included, the confirmation email of these being received by the centre was now attached to the document.

All Staff had completed Fire Safety training which was provided to the team in April 2024. There was a record of attendance on the training company's headed paper provided as they did not provide individual certificates however the attendance record indicated the material covered and included a signature of each attendee. A copy of this was maintained on each team members digital personnel file. First Aid training had been completed the week prior to the inspection taking place. Certificates had not yet arrived to the centre however a record of attendance was provided to inspectors. One staff member required first aid training but inspectors reviewed confirmation of their enrolment in this course which was completed two days following this review. Records of mandatory training was maintained within the training folder in the staff office. This included certificates of completion of the centre's mandatory training and additional training completed. An electronic record was also maintained of these certificates and a live training audit document was in place which

included dates training was completed and signposted when training was due/overdue. Where refresher training in the behaviour management framework was required there was a plan in place for each staff member for this to be completed within the coming months. Additionally, inspectors noted that mandatory training was discussed at weekly team meetings and staff were encouraged and reminded to complete any required training and time was provided weekly for staff to complete training.

The centre had not had any new staff commence since January 2024. Two staff members commenced in January and had induction checklists on file, they had completed probation reviews and had additional supervision in line with policy. Within a sample of personnel files reviewed, one staff member who had continued to work in a relief capacity in the centre prior to applying for a full-time position, did not have an up-to-date CV on file. This had been highlighted within the interview but had not been received at the time this inspection occurred.

The centre had introduced an internal auditing system. This included monthly file audits completed by the centre manager and deputy manager. It was the mechanism through which care practices were reviewed. Feedback on practice issues arising from these audits were provided to the governance manager through weekly management meetings. The file audit included the identified deficits within the young people's files however did not include narrative around practices. The centre had also introduced a service improvement audit. Within this audit form the governance manager detailed their schedule for oversight of centre audits and areas for improvement. In the absence of the narrative within the file audit it was difficult to track why actions around service improvement were being put in place. It was acknowledged by inspectors that these audit systems were still in the infancy, but further development to ensure qualitative data to assess compliance with the National Standards for Children's Residential Centres, 2018 (HIQA) is included within the auditing processes.

Further Action Required

- The centre manager must ensure that the actions outlined in the CAPA under this theme continue to be implemented into practice within the centre.

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

Compliance with standards	
Practices met the required standard	Not all areas under this standard were assessed
Practices met the required standard in some respects only	Standard 6.4
Practices did not meet the required standard	Not all areas under this standard were assessed