An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 048

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Positive Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**09th, 10th & 11th March 2021**
Registration Status:	**Registered from the 16th July 2020 to the 16th July 2023**
Inspection Team:	**Paschal McMahon** **Anne McEvoy** **Michael McGuigan**
Date Report Issued:	**15th September 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 determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 16th July 2011. At the time of this inspection the centre was in its fourth registration and was in year one of the cycle. The centre was registered without attached conditions from 16th July 2020 to 16th July 2023.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was relationship based and had four pillars: entry; stabilise and plan; support and relationship building; and exit. The centre had an emphasis on attachment theory while focusing on the development of relationships with the young people. There were three young people resident in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.2, 3.3
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1,6.4

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 9th of July 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 satisfactory completed action plan (CAPA) on the 21st July 2021 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: 048 without attached conditions from the 16th July 2020 to the 16th July 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

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.

Inspectors found at the time of inspection that each young person had an up-to-date care plan and there was evidence on file that regular statutory reviews had taken place in accordance with the regulations. A review of centre records and interviews with management, staff and allocated social workers confirmed that they worked collaboratively to implement the young people's care plans. Inspectors viewed evidence on file of young people being encouraged to attend their care plan review meetings. On occasions when they chose not to attend they usually completed a young person's review form and work was completed with them in advance to ensure their views were represented at the meeting and the manager and staff advocated on their behalf.

Each young person had a placement plan on file which covered a three month period. The placement plans outlined the purpose of the young person's placements, identified their needs and the supports required. The placement plans were linked to the goals of the care plans and were reviewed and updated monthly to reflect any updates following care plan reviews or any other significant issues or concerns arising. Staff interviewed were aware of the goals of the care and placement plans and the individual work that had been undertaken with the young people which was evidenced in the key working records on file viewed by inspectors.

Each young person's placement plan had a young person's input section which documented the young person's views and their input into their key working goals was sought on a monthly basis at house meetings and key working sessions. The placement plans also recorded the views of the young people's families, social workers and guardians ad litem noting their views on the placement and identifying what goals and supports they wished put in place to support the young people.

The inspectors were satisfied that the young people had access to identified external supports in line with their care plans. The young people were linked in with a

number of specialist services including the Child and Adolescent Mental Health Service (CAMHS), Assessment Consultation Therapy Service (ACTS) and the disability services. The organisation also had their own psychologist who developed therapeutic plans for the young people and provided clinical guidance to the staff team. The centre manager and staff reported that there was effective communication with the young people's social workers and this was reflected in centre records. Social workers interviewed in the course of the inspection confirmed that there was good communication and that the centre were proactive in meeting the needs of the young people.

Compliance with Regulation

Regulation met	**Regulation 5** **Regulation 17**
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	**None Identified**
Practices did not meet the required standard	**None Identified**

Actions required

- None Identified

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

The inspectors found from interviews and a review of care files that the centre had a positive approach to managing behaviour. The centre had behaviour management policies in place which staff were familiar with in interview. All staff were trained in an approved model of behaviour management and there was evidence of regular refresher training being completed. Each young person had an individual risk management plan which detailed active risks, preventative measures and appropriate responses.

Inspectors found that the current resident group were generally well settled and that there was a low level of recorded incidents in the year prior to inspection. Staff interviewed highlighted the experience of the management and staff team and the quality of relationships they had developed with the young people as a key component in behaviour management. When incidents took place or there were behaviours of concern there was evidence on care files that individual key working, significant conversations and life space interviews were conducted.

It was evident from centre records and interviews that staff had a good understanding of the underlying causes of behaviour and did not rely on sanctions to manage the young people's behaviour. Sanctions records viewed by inspectors showed limited use of sanctions and evidence that positive behaviour had been rewarded. Staff were provided with clinical guidance from the organisations psychologist and external specialists to enable them to provide positive behavioural support and assist them in understanding the underlying causes of behaviour and presenting issues.

Each young person had an ICMP (Individual Crisis Management Plan) on file which recorded current behaviours, triggers, high risk behaviours and safety concerns along with de-escalation strategies. Inspectors noted at the time of inspection that one of the ICMPs did not give clear guidance to staff regarding the use of physical restraint. This was brought to the attention of the centre manager and an updated ICMP was subsequently forwarded to the inspectors to address this issue.

The centre had an anti -bullying policy in place and there were no recorded incidents of bullying in the centre in the period under review. It was evident from centre records and interviews that staff were attuned to the young people's needs and there was evidence that key working had been carried out with young people to assist them in managing their mental health during Covid restrictions. Discussions and key working had also taken place with young people in regards to diversity and the need to be respectful of the rights of others.

The centre had a number of auditing systems in place which included a review of behaviour management in the centre. Inspectors reviewed a sample of these audits and were satisfied that they were appropriate internal and external mechanisms in place to ensure there was sufficient oversight of the centres approach to managing behaviour. Social workers in interview were satisfied with the centres approach to behaviour management and were satisfied that incidents had been managed well. The centre had a written policy on the use of restrictive procedures. At the time of the inspection there were two permitted restrictive procedures in place which were

the use of bedroom door alarms at night-time and the use of physical restraint. Both restrictive procedures were subject to risk assessments that were regularly reviewed. There were no recorded physical restraints in the year prior to inspection. Inspectors were satisfied that there were mechanisms in place for the monitoring and oversight of restrictive practices in the centre.

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

The inspectors were satisfied that an open culture was promoted in the centre. Inspectors found that young people's meetings were held regularly and the young people were supported by staff and managers to raise concerns, express their views and have their voices heard. All of the young people in their questionnaires could identify members of management and staff that they could speak with if they had an issue or concern. They reported that they were aware of the centres complaints process and were satisfied with responses they received to complaints which resulted in appropriate action being taken and issues resolved to their satisfaction. Key work records viewed by inspectors also showed that work had been undertaken with the young people to ensure they were aware of the complaints process. Staff in interview stated there was an open culture in the centre and expressed confidence in centre management.

There was evidence across a range of records including care plans and placement plans that the centre consulted and sought feedback from parents, social workers and other relevant professionals to determine their views on the quality of care being provided. The centre maintained appropriate contact with families through telephone contact and facilitating family visits. Social workers interviewed stated that the centre management liaised with them regularly and they were satisfied with the progress the young people had made in their placements.

The centre had a policy on the notification, management and review of incidents and inspectors were informed by the allocated social workers that all incidents were reported in a prompt manner both via phone and e-mail. There was good evidence of oversight by the manager and regional manager who reviewed and commented on the management of all incidents. Incidents were discussed at team meetings and in staff supervision and learning was communicated to the staff team. All incidents were risk rated and high risk incidents were reviewed by a significant event review group. Staff in interview referred to a recent review that took place with a young person's social worker to review a young person's absconcions from the centre and the learning outcomes and changes made following this review.

Compliance with Regulation	
Regulation met /not met	**Regulation 16**

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

Actions required

- None identified

Regulation 5: Care Practice s 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.

There was evidence of consistent leadership in the centre. The manager and deputy manager had been in post for six years and provided stable management and leadership to the staff team. The social care leader in post was also experienced having worked in the centre for over five years. There was a culture of learning in the centre which was evident across a range of records including team meetings and supervision records and a number of well-developed auditing systems.

There were clearly defined governance arrangements in place and all staff were aware of the management structure and their roles and responsibilities. The centre manager reported to a regional manager. The regional manager expressed confidence in the centre management and this was reflected in the audits of the centre viewed by inspectors. Staff also reported that the regional manager and the organisations client services manager visited the centre on a regular basis, conducted audits and were accessible to both young people and staff.

There was a service level agreement in place with the Child and Family Agency and regular meetings took place with the organisations client services manager.

The centres policies and procedures presented for inspection were updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence of an on-going review of policies and procedures by both the organisation and by external consultants. All staff members had received refresher training in the centres policies and procedures in November and December 2020.

The centre had a risk management framework in place for the identification assessment and management of risk. The centre maintained a risk management folder in which specific risks were identified and assessed. Staff had a good working knowledge of managing risk in the centre and risk management was an agenda item at both team meetings and unit manager weekly link in meetings. Current and on-going risks were rated and tracked by the centre manager and the regional manager through their oversight of records and audits.

Inspectors found post inspection that there were two months in the year prior to inspection when the organisation made a decision to reduce staffing levels which inspectors were informed was a control measure to help curb the risk of a Covid-19 outbreak in the centre. In January 2021 the centre reduced its staffing levels from three to two staff members on shift each day. Inspectors were told that this decision was risk assessed, social workers were informed and the centre statement of purpose had been amended to reflect the new staffing arrangements. Inspectors reviewed the risk assessment and noted that it was a general health and safety risk assessment and did not assess the risks posed by a reduction in staffing on the care of the young people. The registered provider must ensure that any risk assessment in relation to a reduction of staffing must include an assessment of the risks posed to the care of the young people.

From a specific analysis of the rosters, daily logs and handover records for January inspectors found that rostering practices were inconsistent and did not correlate to the risk assessment on Covid-19 that was provided to inspectors. Further, upon review of this risk assessment it was noted that this was created by a member of the staff team, not by the centre manager or the regional manager. This was not consistent with risk management processes in the organisation. Any risk assessment on the reduction of staffing should be conducted by senior managers, be time limited and consider the impact on young people placed in the centre. Inspectors did not

find evidence that this risk assessment was regularly reviewed. This issue in regards to a reduction of staffing levels is also addressed further on in the report.

Inspectors found that there were protocols and procedures in place for the management of the Covid-19 virus. Staff interviewed confirmed the centre had adequate supplies of anti-bacterial products, hygiene equipment, personal protective equipment and that there was an increased cleaning regime in place.

There was an appropriate internal management structure in place and there were arrangements in place to provide adequate managerial cover when the manager took periods of leave. The deputy manager deputised for the manager in their absence. During periods when the centre manager was absent from the centre the inspectors were provided with a written record of managerial duties delegated to members of staff detailing their responsibilities and designated tasks.

The centre had an on call system in place to support staff at all times to manage incidents and risks in the centre.

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

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

Actions required

- The registered provider must ensure that any risk assessment on the reduction of staffing is conducted by senior managers, is time limited and considers the impact on young people placed in the centre.

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.

From a review of staff files and rosters for this centre inspectors found that the registered provider had recruited staff with the necessary qualifications, skills and competencies to provide care and support to the young people placed there. The centre staff team was made up of one social care leader and eight social care workers. The inspection information provided stated that there was a dedicated pool of two relief staff to supplement the team where necessary. Inspectors found that the centre manager was suitably qualified and had sufficient practice and management experience for this post. The centre manager was supported by a deputy manager.

Minutes of management meetings and audits viewed by inspectors showed that the centre undertook workforce planning and that staffing requirements were reviewed as necessary. At the time of inspection the centre had nine contracted staff. Five of the staff had social care qualifications while other staff qualifications included social work and community and youth work. Inspectors found there was a stable team in place. Six of the staff had worked in the centre for over two years and there was a good balance of experience, skills and gender across the team.

The centre manager and the regional manager stated in interviews that the staffing ratio in the centre was 1:1 and there were always three staff on duty. Staff rotas provided by the centre manager at the time of inspection also showed that there was three staff on duty each day. However, inspectors found that a complaint had been made by a young person in relation to staffing shortages in January 2021. When this was investigated further post inspection, inspectors found it difficult to verify staffing arrangements as the rosters provided to inspectors at the time of inspection were later found to be inconsistent and inaccurate. In one case inspectors were sent three different rosters for one month. Inspectors were not satisfied with the explanation on why inaccurate information on rostering was provided during inspection and this matter has been referred to the National Registration Enforcement Panel.

Inspectors observed that the roster pattern in the centre was two overnight shifts and one 16 hour day shift each day. From a review of the rosters for January - March

2021 inspectors found that the centre did not have enough staff to meet this roster pattern. At times relief staff and the deputy manager were working shifts to make up the shortfall in staffing. At other times the cover in the centre was reduced to two staff only. The centre requires at least one more full time staff member to fulfil the roster in operation. Inspectors found 35 instances in January 2021 where staff worked back to back shifts and were in the building for 48 hours. From a review of daily logs inspectors also found that night checks were being carried on one young person for a period in January and February. However, live night cover was not in place during this time and the checks had to be carried out during the night by the sleepover staff. In some instances staff were working 48 hours continually (back-to-back) and were required to get up during the night on successive shifts to conduct live night checks. This practice is unsafe and if night checks are required then live night staff must be rostered to carry these out. The practice of staff working back-to-back shifts in the organisation must stop immediately.

From a review of the daily logs and handovers post inspection, inspectors subsequently found that on six days in December 2020 and 20 days in January 2021 there were only two staff on shift. This was also the case for three days in February and three days March 2021. When this was queried with centre managers they wrote to inspectors stating that the reduction in staff in January 2021 was based on a risk assessment and was a control measure to prevent the risk of a Covid-19 outbreak in the centre.

Inspectors noted in January 2021 that a young person was referred for a Covid-19 test. However, staffing was not reduced to two persons at this time and remained at three. This was not consistent with the risk assessment on reduced staffing related to Covid-19. Inspectors noted that there was no clear pattern on the increase or decrease in staff on certain days. There were days when three staff were on shift but there were no extra duties or increased appointments for young people. The staffing arrangements in the centre were inconsistent and did not correlate with the risk assessment that was in place at that time.

The Tusla National Private Placement Team were also not informed of the decision to reduce staffing levels for the month of January 2021. The registered provider and centre management must ensure that when changes occur in the staffing rota that this must be reflected in the final archived rosters maintained by the organisation and made available for inspection. The registered provider must also ensure that staffing arrangements must reflect the agreed staffing allocation as agreed and funded by the national private placement team.

Inspectors found that due to reduced staffing in the centre there were periods of lone working when only two staff were on shift and one left the building. However, the lone working logs provided to inspectors did not contain specific details on these periods and inspectors could not verify when staff were alone in the building with young people and for how long. These records must be reviewed and corrected by the regional manager.

The organisation had a range of systems in place to promote staff retention. This included the provision of on-going training, career progression opportunities and access to healthcare and an employee assistance programme. The guidance and expertise of the management team, a healthy team dynamic and a supportive working environment were identified by staff as positive aspects of working in the centre.

There was a formal on call policy and procedure in operation which staff found responsive and provided them with good guidance and support.

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

Inspectors were satisfied that all staff working in the centre had received training and development opportunities relevant to their role in line with the requirements of legislation, standards and guidelines, and the needs of the young people. All the staff in the centre had the relevant mandatory core training and received refresher training as required. The organisation had its own on line training portal which provided a range of training courses for staff. Staff interviewed and in their questionnaires confirmed that there were provided and availed of on-going training opportunities.

The manager and regional manager has oversight of training needs in the centre. There was evidence in centre records that the managers were proactive in identifying additional training requirements and liaising with the organisations training department and/or external sources to source relevant training. The inspectors viewed a monthly staff training schedule listing planned training which included medication management, policies and procedures, behaviour management and first aid.

The centre had a formal induction policy in place. New staff members were required to undertake a five day company induction prior to working in the centre during which they received the required core training. An in-house specific induction

process was then commenced with the new staff member by one of the centre managers or a senior member of staff. This process included the completion of an induction checklist which was completed over time and reviewed in supervision. Inspectors found completed induction forms on all personnel files reviewed during the course of the inspection.

Staff members training records were maintained centrally by the organisations training department and on staff personnel files. Inspectors reviewed a number of personnel files during the inspection and found that the training records were up-to-date and there were training certificates on file.

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

Compliance with standards	
Practices met the required standard	**Standard 6.4**
Practices met the required standard in some respects only	**None Identified**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The registered provider must ensure that the centre has sufficient numbers of staff to fulfil the roster in operation.
- The registered provider must ensure that the practice of staff working back-to-back shifts in the organisation must stop immediately.
- The registered provider must ensure that when changes occur in the staffing rota that this must be reflected in the final archived rosters maintained by the organisation and made available for inspection.
- The registered provider must also ensure that staffing arrangements must reflect the agreed staffing allocation as agreed and funded by the national private placement team.
- The regional manager must review and correct the lone working logs to ensure they accurately record the periods and duration that staff were alone in the centre with the young people.

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 any risk assessment on the reduction of staffing is conducted by senior managers, is time limited and considers the impact on young people placed in the centre.	This has now been included as part of the centre's Statement of Purpose's risk register with clear risk ratings and control measures for planning highlighted taking into account the impact on the young people in the centre.	Reduced staffing as a risk is now included in all centre's risk registers across the organisation and risk rated accordingly in order for all services to have a contingency plan in place and to alert senior management if the rating increases in order to respond to same.
6	The registered provider must ensure that the centre has sufficient numbers of staff to fulfil the roster in operation. The registered provider must ensure that the practice of staff working back-to-back shifts in the organisation must stop immediately. The registered provider must ensure that when changes occur in the staffing	The centre has now over contracted in staffing to ensure that they are not solely reliant on the usage of relief staff to cover any types of leave. The centre will endeavour to ensure that back-to-back shifts do not take place. The organisation has a Time Management system in which the roster is electronically	The organisation has over contracted in staffing to ensure adequate staffing is available to fulfil the centres' roster requirements in line with occupancy. The organisation will endeavour to ensure that back-to-back shifts do not take place. The organisation will no longer operate from paper rosters and only rosters from

	rota that this must be reflected in the final archived rosters maintained by the organisation and made available for inspection.	stored. Paper rosters will no longer be in use.	the Time Management System will be utilised. Final versions of same will be stored in each centre and available for each inspection.
	The registered provider must also ensure that staffing arrangements must reflect the agreed staffing allocation as agreed and funded by the national private placement team.	A daily staffing report is now in operation and overseen by senior management to ensure adequate staffing is in place daily as per agreement with the National private placement team.	Daily staffing reports are completed on the organisations internal system where each centre manager reports in on staffing daily. This is circulated to senior management and provides assurances that staffing arrangements are reflective of the agreements in place for each young person with the national placement team.
	The regional manager must review and correct the lone working logs to ensure they accurately record the periods and duration that staff were alone in the centre with the young people.	Lone working logs have been reviewed and are now recording accurately the information needed to ensure that it is clear when lone working has occurred, and times and staff are specific.	Training has taken place in relation to the importance of recording and the procedures for same when lone working with young people across the organisation with regional managers attending team meetings to deliver same.