An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 009

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Galtee Clinic**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced inspection**
Date of inspection:	**04th, 05th, and 06th August 2021**
Registration Status:	**Registered from the 19th October 2021 to the 19th October 2024**
Inspection Team:	**Linda McGuiness** **Paschal Mc Mahon**
Date Report Issued:	**17th November 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 in 2015. At the time of this inspection the centre were in their second registration and were in year three of the cycle. The centre was registered at that time without attached conditions from the 19th October 2018 to the 19th October 2021.

The centre's purpose and function was to accommodate four young people of both genders from age thirteen to seventeen years on admission. The model of care was informed by the principles of social pedagogy. Relationships between the adults and young people were central to the work of the centre. There were four young people placed in the centre at the time of this inspection. One of the young people was under 13 years and therefore outside the scope of the stated purpose of the centre. They were placed under a derogation which remained under regular review.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 12th August 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 24th August 2021. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

On review of the application for re-registration of this centre made on 23rd August 2021, it was found that the balance of staff in the centre did not meet the regulatory requirements and also that the centre did not hold a planning exemption for their operation. The registered proprietor was informed on 8th of September 2021 of a proposal to attach a condition to the registration until the centre was compliant with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 7 Staffing. The proprietor was also required to submit evidence of the planning exemption for the centre to be a children's residential centre.

Representations were received on the 21st of September 2021, the 29th of October 2021 and the 12th of November 2021. These were reviewed and accepted by the Alternative Care Inspection and Monitoring Service. It was found that the centre now meets the staffing requirements to comply with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 7 Staffing. The planning exemption was also received.

As such it is the decision of the Child and Family Agency to register this centre, ID Number: 009 without attached conditions from the 19th of October 2021 to the 19th of October 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

At the time of inspection there was an up-to-date care plan on file for two young people placed in the centre. A child in care review had taken place for a second young person but no updated care plan was provided. There had been significant changes in the long-term plan for this young person who was engaged with the aftercare service. The social work department informed the inspector that they had decided to convene another statutory review meeting after which a care plan would be provided. While some delays were understood in the context of the HSE cyber-attack, inspectors found that delays in receiving statutory care plans was a recurring issue in the centre which required action from social work departments.

Until recently, one young person placed under derogation had only one care plan on file since July 2020. While monthly child in care review meetings were now taking place in line with the *HSE National Policy on the Placement of Children 12 years and under in the Care or Custody of the Health Service Executive*, no updated care plans were provided in that time despite changes in planning through that period. There was no evidence that this issue had been addressed in a timely way. Despite being highlighted by senior management it had not been promptly escalated by them to senior management within the social work department to ensure that care planning was in line with regulatory requirements.

All four young people had up to date placement plans prepared by their primary activity therapist for the period June to August/September 2021. For two young people who had a care plan on file, the placement plan was in line with the identified needs and individual work took place to address the goals on the plan. The placement plans for the other two young people were drawn up from the staff knowledge of the of the young people, referral information and assessments provided to the centre before their admission. There was improved evidence since the last inspection of this centre that placement plans were discussed at team meetings and with staff in supervision. Inspectors found that the social pedagogues and activity therapists conducted individual work with young people to progress placement plan

goals. Placement plans were reviewed regularly, and progress reports were prepared and reviewed by the centre manager and service manager.

Young people were encouraged to attend their child in care review meetings. Where they chose not to, there were measures in place to ensure their views were fully represented.

In consultation with supervising social workers, young people's families were invited to input to the placement planning process through child in care review meetings. There was regular communication between families and the manager/assigned activity therapists to update them on their child's progress. The parents of two young people spoke to inspectors and commended the work and commitment of the team and management. They were happy with the progress the young people had made through the placement and were appreciative of the high quality care being provided.

Inspectors found that in general young people had timely access to appropriate specialist supports; however, court ordered therapeutic input for one young person was significantly delayed. The proposed therapist who had indicated that they would provide a service was no longer available. This therapy is a key part of onward planning for the child and must be sourced as a matter of priority. The director was a clinical psychologist and there was evidence that they attended team and planning meetings, provided support to the staff team and, on occasion also to families. This person also provided training in attachment and social pedagogy in line with the model of care.

Inspectors reviewed care files and found that while there was regular telephone communication with social workers, improvements were required in how this contact was recorded. Inspectors also found that while there was a pre-admission risk assessment in place, this was signed off and progressed without evidence of consultation with the social workers for other young people. All four social workers who spoke to inspectors spoke highly of the service provision to their young people and the strong relationships with key staff members. However, they were not generally sent copies of placement plans or progress reports unless they requested it and their input into the placement planning process was not evident. There was a lack of evidence of communication with social workers which they confirmed often took place informally by telephone.

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

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

Actions required

- The registered provider must ensure that there is a system in place to ensure timely escalation when care planning is not in line with regulatory requirements or national policy.
- The registered provider must ensure that consultation with social workers of all young people takes place during the pre-admission risk assessment. This, along with any subsequent control measures must be recorded on young people's care files.
- The registered provider must ensure that there is evidence of effective communication with supervising social workers and that they are sent copies of all relevant planning documents for consultation and approval.
- The registered provider and supervising social work department must ensure that the court ordered therapeutic specialist support for one young person is sourced and commences as a matter of priority.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

There was an organisational structure in place which clearly outlined the governance arrangements and accountability. The centre manager held an appropriate qualification and the required experience for the post. From interviews with staff and social workers and review of centre files it was evident that the centre manager demonstrated day-to-day leadership and governance in the centre. All staff, parents and professionals who were interviewed during the inspection process were satisfied with the management of the centre. At the time of inspection, discussions were taking place at senior management level to support the manager with their heavy workload. Some responsibilities had been delegated to the service manager. A review of management meetings and supervision records evidenced discussions relating to supporting the centre manager.

At the time of inspection, a review of the suite of policies and procedures was on-going. A number of quality improvement days took place and this demonstrated on-going work on this issue. A timeframe of September 2021 for the completion of the policy update was provided to inspectors. There was evidence of discussions relating to policies, procedures and practice at team and management meetings.

There was evidence that the service manager and service director had each visited the centre and met with staff and young people. They both attended team and management meetings. They had access to centre records many of which were held off-site as it was organisational policy not to have an office in the centres. This was in keeping with the model of care which focused on maintaining a family like environment. A new system of oversight and auditing was recently implemented following an inspection of another centre in this organisation. This involved a self-audit process which was subject to oversight and quality assurance by the service manager who then prepared a report and action plan. There was evidence of good oversight of day-to-day operations and some areas of practice. Some further improvements were required to ensure that all aspects of the National Standards for Children's Residential Centres, 2018 (HIQA) were covered. For example, the audits, report, or action plans did not evidence thorough review of complaints or restrictive practices. Inspectors found that one SEN which should have resulted in a Significant Event Review Group (SERG) meeting to review how staff may have contributed to the causes of challenging behaviour was not picked up by external auditing. While the manager stated that this issue was addressed informally with the staff and they explained it as a language issue, inspectors found this incident required evidence of a more robust analysis.

Inspectors found that on occasion, some of the centre records were written in language which was not child friendly and may have indicated a requirement to review care practice. At the time of inspection, the centre manager assured inspectors that this had been addressed. However, in two instances there was a lack of evidence of oversight of this by the centre and service manager with follow up in staff supervision or in the SERG.

There was a service level agreement in place and there was evidence of reports being provided to the funding body. The service manager was the person in charge with overall accountability, responsibility, and authority for the delivery of care. Inspectors found that the internal management structure was appropriate to the size and function of the centre and specific model of care.

There was an on-call system in place to provide support and guidance out of office hours. The manager and staff reported that this worked effectively in practice. There was written evidence of delegated duties to other people, for example when the centre manager took parental leave or during periods of other leave by service managers.

There was a risk management framework and supporting structures in place for the identification, assessment, and management of risk. The organisational risk register contained risks and control measures which were rated and then re-rated following the implementation of control measures. While inspectors were generally satisfied that the risks associated with the young people were comprehensively risk rated and managed there were a number of deficits where responses to risk required improvement and oversight. During a period of crisis for one young person they displayed significant violent and aggressive behaviour in the centre. Staff were assaulted and three other young people complained about the violence. This was significant for all young people and was acknowledged by staff and management who implemented measures to ensure safety. It was on the centre risk register and had been discussed at team and management meetings. Notwithstanding this, inspectors found that one young person who witnessed three of these episodes was 8 years old and they had expressed their fears to staff. Inspectors found that this child's experience was not adequately recorded on the daily log, was not promptly notified to their social worker until they made a complaint many weeks later. While measures were put in place to provide extra supervision and the young person was reassured, there was no risk assessment or safety plan for this or the other young people.

There was also an issue relating to a young person's absence from the centre at night (unknown to staff) which inspectors found was not adequately risk assessed. Also,

broken alarms in the centre had not resulted in a revision of risk rating on the register.

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

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

Actions required

- The registered provider must ensure that any risk relating to young people being exposed to violence is notified promptly. They must ensure that there is robust evidence of how the issue is being addressed through risk assessment, safety planning and a thorough complaints process
- The centre manager and service manager must ensure that evidence of their oversight of care practice/records and subsequent actions is appropriately recorded.
- The registered provider must ensure that all risks are adequately assessed and subject to review.

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.

Staff recruitment and retention was the responsibility of senior managers in the organisation. There were established links with a college which specialised in social pedagogy to facilitate workforce planning. There was evidence of discussion relating to workforce planning in team meeting and management meetings. Planning considered annual leave, sick leave and maternity/parental leaves.

The centre had sufficient numbers of staff working in the centre, however there had been a significant staff turnover in 2020 with only two of the core team remaining. This was explained in the context of Covid-19 as many of the social pedagogues were from abroad and felt the need to return home as travel was not permitted. Two other couples were recruited as well as new activity therapists with relevant qualifications and the team was stable with no changes since November 2020.

There was one dedicated relief staff and three others available to cover annual or other types of leave. During interviews with staff members, inspectors found that staff demonstrated that they had the relevant competencies to meet the needs of the young people.

There were some measures in place to ensure staff retention. These included training, employee assistance, supervision, and support as well as staff bonuses. Social Pedagogues generally committed to at least 18 months working in the centre at the time of their appointment.

There was a formalised procedure for on-call arrangements at evenings and weekends.

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

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

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered proprietor must ensure that there is a system in place to ensure timely escalation when care planning is not in line with regulatory requirements or national policy.	Development of an escalation policy which will outline the process for escalating concerns re care planning to relevant parties. Policy will detail levels of escalation and who is responsible for escalating concerns at each level and in what timeframe. Escalation policy to be developed and rolled out by end of September 2021.	Care planning and placement planning are recorded as part of the monthly internal audits and reviewed by the service manager. Any outstanding care planning requirements will be escalated to all relevant parties in line with the escalation policy. Efforts to obtain care planning documents will be recorded in young person's care records.
	The registered provider must ensure that consultation with social workers of all young people takes place during the pre-admission risk assessment. This, along with any subsequent control measures must be recorded on young people's care	Pre-admission risk assessment template reviewed to include consultation with social workers and Guardians ad litem and their views recorded. Centre manager responsible for following up with all relevant social workers and service manager to review pre-admission risk assessment to ensure all parties have been	Admission policy to be updated to highlight the responsibilities of all parties during the pre-admission risk assessment and this policy to be discussed at next quality improvement day in September.

	files.	notified and their views recorded. Immediate effect.	
	The registered proprietor must ensure that there is evidence of effective communication with supervising social workers and that they are sent copies of all relevant planning documents for consultation and approval.	Centre manager, service manager and team members will keep a written record of all contact with social workers and this will be filed in the relevant section of the young person's care records. Care planning and placement planning documents inclusive of placement plans, progress reports, positive supports plans, safe plans and risk assessments will be emailed to supervising social workers and Guardians ad litem where appropriate. Effective immediately.	Monthly internal audit template and weekly governance report template will be reviewed to include contact with social workers and Guardians ad litem. Service manager will review care records in line with these internal audits/reports to ensure records are being maintained and all paperwork is being shared with social workers. Effective immediately.
	The registered provider and supervising social work department must ensure that the court ordered therapeutic specialist support for one young person is sourced and commences as a matter of priority.	Specialist support was discussed in August 2020 and sourced in October 2020 but has been significantly delayed as a result of covid19. Specialist support is being explored for this young person and young person has been added to a waiting list for required specialist support. Centre manager will make contact with other services providing	Specialist support was sourced in October 2020 but has been significantly delayed as a result of covid19. Specialist supports required will be discussed at clinical management meetings to ensure that planning for same continues to occur in a timely manner and are prioritised.

		specialist support to enquire about their waiting lists.	
5	The registered provider must ensure that any risk relating to young people being exposed to violence is notified promptly. They must ensure that there is robust evidence of how the issue is being addressed through risk assessment, safety planning and a thorough complaints process.	All risk assessments to be emailed to social workers for review and consultation. Effective immediately**.** All incidents of violence require a significant event review group (SERG)/clinical review meeting. Risk assessments, safety plans and the voice of all young people involved will be discussed and appropriate safeguarding plans drawn up. These plans will be shared with all supervising social workers. Effective immediately.	Service manager and clinical director to attend significant event review group for incidents that include violence. They will oversee that an appropriate action plan has been completed including the notification of incidents. Weekly governance report submitted to service manager and clinical director that reports on significant events, risk assessments and complaints**.**
	The centre manager and service manager must ensure that evidence of their oversight of care practice/records and subsequent actions is appropriately recorded.	Care practice and care records to be discussed in supervision, team meetings, SERG and clinical management meetings and records of same filed accordingly. Oversight of care practice and records that takes place outside of these forums to be recorded by centre/service manager and	Continuous professional development is a standing agenda item on supervision records and centre manager and service manager will create professional development plans for team members where required. Weekly governance report takes into

		filed accordingly in young person's care records, supervision and personnel files. Effective immediately.	account additional support required for team members and oversight of care practices will be recorded here also. Effective immediately
	The registered provider must ensure that all risks are adequately assessed and subject to review.	Risk assessments will be updated when control measures change. An updated risk assessments will be shared with social workers and Guardians as Litem. Risk assessments will be discussed at team meetings, SERG, and clinical management meetings. Risk will be re-entered into the risk register and level of risk updated as control measures change. Effective immediately.	Risk assessments are recorded on internal monthly audits and weekly governance reports for the centre. The service manager reviews these monthly audits and governance reports and will ensure that all risk assessments are reviewed, updated and monitored as required. Risk register is reviewed in line with this process.