Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 044
Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Positive Care**
Registered Capacity:	**Four young people**
Dates of Inspection	**27th and 28th February 2020**
Type of Inspection:	**Announced**
Registration Status:	**Without attached conditions from 08th June 2018 to 08th June 2021**
Inspection Team:	**Anne McEvoy Joanne Cogley**
Date Report Issued:	**24th April 2020**

Contents

1. Information about the inspection **4**

1.1 Centre Description
1.2 Methodology

2. Findings with regard to registration matters **8**

3. Inspection Findings **9**

3.1 Theme 3: Safe Care and Support
3.2 Theme 5: Leadership, Governance and Management

4. Corrective and Preventative Actions **17**

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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 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

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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 in June 2015. At the time of this inspection the centre was in its second registration and was in year two of the cycle. The centre was registered without attached conditions from 08th June 2018 to the 08th June 2021.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. However at the time of inspection, the centre had three young people resident, two young people aged 12 and under and one young adult over 18 years of age. The placements for the two young people under thirteen were agreed with the national derogations officer and the placement for the young adult had been approved by the inspector manager. The model of care was relationship based and had four pillars: entry; stabilise and plan; support and relationship building; exit. This model included work on trauma and family relationships while setting meaningful life goals for the young person.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews 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 and centre manager on the 30th March 2020 and to the relevant social work departments on the same date. 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 3rd April 2020. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

Inspectors reviewed the child protection policies in place and found these to be compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017. The centre also had an appropriate child safeguarding statement and a letter of compliance to say that this had been reviewed and approved by the Tusla Child Safeguarding Statement Compliance Unit. The centre also had policies on protected disclosure and anti-bullying and arrangements were in place to inform parents of allegations of abuse. No issues of bullying were reported within the centre and the young people reported that they had not experienced bullying. There were reports of usual peer interaction which was managed by the centre in key working sessions with the young people. In interview, staff demonstrated an understanding of the relevant legislation, centre policies and standards appropriate to their roles.

Staff in the centre had received appropriate education and training regarding recognising and responding to allegations of abuse both at induction and on an on-going basis. Staff training records evidenced that most staff members had completed training in the centres policies on child protection and all staff had completed the Tusla e-Learning module: Introduction to Children First, 2017. It was noted by inspectors that two of the sample of personnel files examined evidenced that those staff members had completed their child protection organisational training in 2016 and 2017 respectively, prior to new legislation coming into effect and one staff member had not completed it at all. The centre manager and regional manager must ensure that child protection training is updated and all staff receive relevant training. Both the young people's care plans and placement plans took account of the need to keep them safe.

There was evidence of staff working in partnership with the young people, their allocated social worker and where appropriate the parents/guardians. There were agreements in place for the social workers to be responsible for contacting parents/guardians where appropriate. There was evidence of regular contact with the young people's social workers to report incidents of concern, to update in relation to the young people and to plan for the young people.

It was evidenced that child protection was a standing item at both staff team meetings and operations manager's meetings and during interview staff demonstrated an understanding of their obligations under Children First: National Guidance for the Protection and Welfare of Children, 2017 and their roles as mandated persons. There were policies on safeguarding that were understood by staff and this was also a regular item for discussion in supervision and at staff team meetings. Inspectors found that there were age appropriate programmes in place to support young people in the development of self-care and protection skills. Upon review of key working sessions, it was observed that staff had discussed issues such as mental health, self esteem, sexual education and development (appropriate to the development of the young people in the centre), social media and internet safety. Significant key working had also been completed with the young adult in the centre around safe and healthy relationships, domestic violence and sexual violence.

The centre had created pre-admission risk assessments to identify and address areas of vulnerability for young people and also had risk management plans where necessary. There were risk assessments in relation to each young person that were relevant and current. Each risk assessment had identified triggers and intervention strategies to limit the risk.

Inspectors reviewed the centre child protection register. There was evidence that child protection and welfare reports were appropriately being completed and forwarded to the social work department. There was evidence of centre management following up with the relevant social worker to ascertain the outcome and all documentation was kept together in a sealed envelope in the young person's care file.

The centre had a protected disclosure policy and all staff demonstrated an awareness of this policy and the process associated with it and were confident they could implement it if required.

Standard 3.2

Staff had been trained in a recognised model of behaviour management and there was evidence of regular refresher training being completed. There was a policy in place that provided details to the staff team on the nature of and approaches to behaviour management in the centre. During interviews with staff, inspectors found that they understood the approaches to behaviour management and were able to implement this on a day-to-day basis. Staff had access to external support and training around issues that arise such as self harming behaviours and mental health.

There was internal support provided to the staff team through the company psychologist around behaviours that challenge and promoting positive behaviour. Inspectors saw evidence of this resource being utilised in the young people's care files.

Young people were also aware of the expectations for behaviour and there was evidence that key working had been undertaken with them on the issue both on admission and on an ongoing basis.

Each young person had an individual crisis management plan and a behaviour support plan and there was evidence that these were regularly reviewed in conjunction with the allocated social worker. The plans were individualised and reflected the behavioural challenges of the young person. The centre manager and regional manager must ensure that the ICMP for one young person under derogation be reviewed and updated to identify whether or not restraint can be used after their medication is administered as this appeared to be unclear. Social workers for young people had provided sufficient pre-admission referral to the centre and there was evidence of a planned induction.

Inspectors examined a sample of handover logs and found detailed communication being provided daily regarding all information needed to safeguard the young people and best promote their welfare for the following day. Clear guidance was provided in terms of triggers, signs to be watchful for and specific protocols to follow. There was also evidence in team meetings to support a full and detailed transfer of communication enabling discussion around approaches and methodologies to best support the young people.

Monthly audits were carried out by the centre manager and forwarded to management for oversight. These provided an overview of significant events, restraints and sanctions that were used within the centre. Personnel external to the centre in the form of the regional manager and client services manager (in the absence of the regional manager), conducted monthly audits of the centre. These audits were a comprehensive paperwork review focusing on the content and quality of life space interviews, key working sessions following significant events along with rewards and sanctions used within the centre.

Restrictive practices were in use within the centre. These were risk assessed and were reviewed. There were a significant number of physical restraints used in relation to one young person under derogation. Inspectors found that these events

were discussed in the child in care reviews with the social worker and guardian ad litem. They were also discussed in the staff team meetings, with the behaviour management trainer and with the company psychologist. In interview, the allocated social worker stated that they were aware of the volume of restraints and were satisfied that these were used as a last resort and were deemed necessary for the safety of the young person and the staff.

Standard 3.3

The centre had a clear complaints process and this was explained to young people on admission to the centre. In interview, each staff member was aware of the complaints process and the purpose of same. Young people were encouraged to express their dissatisfaction and staff were proactive in recording any complaints. The inspectors reviewed the complaints log for the centre and observed that the log showed evidence of operations manager oversight. Complaints were also a standing item at staff team meetings and regional manager's meetings. There was evidence of social workers visiting their respective young people and young people knew they could speak to their social worker regarding any concerns or complaints they had. The advocacy agency Empowering People In Care had visited the centre and young people knew how to access them if required.

At the time of inspection, the centre had just implemented a mechanism for obtaining feedback on a weekly basis from parents. Inspectors were advised that this action had been included as part of the regional managers monthly audits to ensure completion and oversight. The centre was part of a significant event review group that met when necessary and reviewed incidents for a number of the centres in the region. Learning from incidents was fed back to staff teams and incorporated where necessary into behaviour management plans and individual crisis management plans. Inspectors recommend that the volume of physical restraints be included as part of that review group to ascertain any additional learning that could be gathered from the experience of the group members.

There was a clear policy on the notification of significant events and from interviews with social workers and a review of the reports held on site, inspectors found that these were notified promptly to the appropriate persons and contained the required information.

Compliance with Regulation	
Regulation met	Regulation 16

Compliance with standards	
Practices met the required standard	Standard 3.3
Practices met the required standard in some respects only	Standard 3.1 Standard 3.2
Practices did not meet the required standard	None identified

Actions required

- The centre manager and regional manager must ensure that child protection training is updated and all staff receive relevant training.
- The centre manager and regional manager must ensure that the ICMP for one young person under derogation be reviewed and updated to identify whether or not restraint can be used after their medication is administered as this appeared to be unclear.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The inspectors reviewed the centres policies and procedures and found that they had been updated in line with The National Standards for Children's Residential Centres, 2018 (HIQA). Staff had received training in these standards and there was an on-going training programme in place to familiarise them with new policies and standards. There was also evidence that policies and procedures were discussed at team meetings and with staff in supervision.

In interview staff demonstrated an appropriate level of knowledge about their policies, procedures and legislation governing their practice. Staff questionnaires examined by inspectors demonstrated an in depth knowledge of legislation, policies and procedures.

Standard 5.2

In the five months prior to inspection, there was significant changes in the management structure with four different centre managers in that period of time. In the two months prior to inspection there was no regional manager assigned to the centre. Inspectors found that despite the constant change in management, there was oversight during this time frame. There was always a person assigned the task of person in charge and they were supported firstly by the regional manager and in their absence by the client services manager. During the absence of the regional manager, the client services manager visited the centre regularly and ensured that monthly audits were conducted and action plans followed up on. In interview staff stated that despite the disruption in the centre manager post, they were supported by the deputy manager and social care leader who were experienced in the centre. At the time of inspection, there was a newly appointed regional manager and a newly appointed acting centre manager and the deputy manager continued in post. In interview staff stated they had confidence in all levels of management. They confirmed they were well supported in their work by the internal and external managers and that a culture of learning existed within the organisation.

Each staff member knew the individual role of managers both within the centre and managers external to the centre. Job descriptions had been provided to all staff.

There was a service level agreement in place and reports were provided to the funding body demonstrating compliance with legislation and standards. There was an identified person in charge and all staff and young people in the centre were aware of that person and their role.

The service had recently developed a risk management framework that was set out in a comprehensive written policy and included the establishment of a risk register. All staff had received training on this new risk framework and were familiar with the risk management policy in interviews with inspectors. The centre had a system for identifying, assessing and managing risk for young people within the centre including personal risk and environmental risk. There was a clear process in place for the escalation of risk within the service. There was evidence of shared learning across centres. There was evidence of oversight of risk by senior managers in management meetings, through external managers' audits and during their visits to the centre.

At the time of inspection, there was an internal management structure in place appropriate to the size and purpose and function of the centre. Inspectors reviewed a

sample of rosters and this demonstrated that the centre has a stable cohort of staff available to fulfil the duties required.

There were alternative management arrangements in place for when the person in charge was absent. These arrangements were readily available to all staff. There was evidence of a written delegation record identifying any and all duties assigned from the centre manager to appropriately qualified staff members.

Standard 5.3

There was a statement of purpose and function which met all the criteria set out in the National Standards for Children's Residential Centres 2018, (HIQA). It was recently reviewed prior to inspection and was a current and relevant document. The statement of purpose included the aims, objectives and ethos of the service and detailed the organisational structure describing the management and staff employed in the centre.

The statement of purpose and function was available within the centre. All staff were knowledgeable about its contents and it was explained to young people and parents on admission both verbally and in their booklets.

Staff in interview were aware of the care framework and were able to talk freely on the model of care used within the centre. It was observed in care files that the approaches used in the centre were referenced by staff and by management in relation to working documents for young people.

Standard 5.4

The inspectors found there were clear and well developed systems in place to monitor, improve and evaluate the quality, safety and continuity of care provided to the young people. There were a number of oversight and audit systems in place conducted internally by senior management to assess on an on-going basis the quality of care provision, to analyse staff practice and review outcomes for young people. There was evidence that the centre manager was monitoring the quality of care in the centre through their monitoring of records, observation of staff practice and contact with the young people. They reported to a regional manager who carried out regular monthly audits. In the absence of the regional manager, this role was fulfilled by the client services manager. The inspectors viewed a sample of regional managers' audits and found that action plans developed in these audits led to

improvements in practices. Management and team meetings took place on a regular basis where quality, safety of care and outcomes for young people were discussed.

The centre had a complaints process in place which was understood by both staff and young people. Inspectors reviewed the complaint records on file and were satisfied that the managers were monitoring and analysing complaints to identify any trends to promote learning and improvement.

In interview, inspectors were advised that the annual review of compliance was a working document that was being undertaken by the centre to ensure its compliance with this standard.

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

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

Actions required

- None required

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager and regional manager must ensure that child protection training is updated and all staff receive relevant training. The centre manager and regional manager must ensure that the ICMP for one young person under derogation be reviewed and updated to identify whether or not restraint can be used after their medication is administered as this appeared to be unclear.	All staff members receive child protection training upon induction to the organisation from our internal training department and refresh content every 12 months. All centre staff to receive a refresher training in Child Protection by April 8th 2020. ICMP to be reviewed with the training departments and GP input with clearer guidance for team around restraints following administration of medication – this has already been addressed and completed.	Unit Manager and Regional Manager to review child protection training statistics monthly as part of supervision. Child Protection is part of a rolling agenda for team meetings and reviewed at every team meeting. Changes in ICMP's are monitored through a Unit Manager audit monthly or more frequently if required based on the behaviour of the young person. The training department also review ICMP's where required to ensure that guidance for staff is clear in relation to the usage of physical intervention. This will also be included in supervision for keyworkers for the young people as well as a rolling agenda items at the staff team meetings for review.

5	None required		

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