An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 053

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Rainbows Community Services**
Registered Capacity:	**Five Young People**
Type of Inspection:	**Unannounced**
Date of inspection:	**7th, 8th and 14th August 2024**
Registration Status:	**Registered from 31st March 2022 to 31st March 2025**
Inspection Team:	**Cora Kelly** **Lorraine Egan**
Date Report Issued:	**10th October 2024**

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 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

1.1 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 31st of March 2007. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from the 31st of March 2022 to the 31st of March 2025.

At the request of the organisation and approval by the ACIMS registration committee the centres registered capacity was increased to accommodate an additional young person in March 2024 bringing the centres registered capacity to providing accommodation for five young people from age sixteen to nineteen years in their own apartment with the provision of onsite team supports. Their model of care was described as relationship based with an understanding of attachment and strong core working knowledge of the skills and resilience required for the next stage in the young people's lives. The team was utilising a model of care based on the principles of Daily Life Events (DLE), which looked at everyday tasks and creating positive experiences for them. DLE enforces the importance of using natural opportunities as the focus for interventions with young people. There were five young people living in the centre at the time of the inspection with three over the age of eighteen years.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
5: Leadership, Governance and Management	5.2

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 and one allocated social worker. 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 September 2024. 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 20th of September 2024. On their review the inspectors requested that a further review of the CAPA be undertaken. This occurred with a further and a final CAPA, alongside supporting documentation, received on the 27th of September 2024. This was deemed satisfactory and accepted by the inspectors.

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: 053 without attached conditions from the 31st of March 2022 to the 31st of March 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The centre was a large building that comprised of five individual one-bedroom apartments. Since the last ACIMS inspection in October 2023 a small cabin was added to the property to accommodate staff space that included a kitchen, living and office area with a toilet and shower too. The original staff office was repurposed to increase capacity from four to five young people. A small decking area was also added to the outdoor space. The property did not have a dedicated indoor or outdoor area for staff and young people to come together outside of their apartments or a garden space. The director of services (DOS) submitted the schedule of insurance for the property that included professional indemnity and employer and public liability.

One young person was happy to show the inspectors how they were maintaining their apartment and their newly decorated outdoor space. Through questionnaire four young people indicated that they were happy with their rooms, they had enough space for their belongings and would not change anything.

The centre had a fire safety policy with further fire safety and prevention information contained in the health and safety statement. A member of staff was the appointed fire safety officer. There was written confirmation that the centre was compliant with the requirements of fire safety legislation and building regulations. A new fire system was installed early 2024 with all staff provided with training on the new system. Fire safety training was up to date for all staff.

The young people's apartments had been equipped with fire safety equipment. There was evidence of all firefighting equipment being regularly maintained in line with requirements. At the time of the inspection personal emergency evaluation plans

were not in place for the five young people resident. The centre manager addressed this immediately and developed plans for each young person with copies submitted to the inspectors. It was outlined in the health and safety statement that fire safety drills were to occur on a quarterly basis and / or when a new staff member or young person moved to the centre. The fire and general register did not evidence that fire safety drills were being conducted in line with policy timeframes nor had a fire safety drill occurred during the hours of darkness. For the single fire safety drill held this year to date the complete set of names of those who participated in the fire drill was not recorded. The inspectors were informed that one young person had refused to take part in the drill. A risk assessment for this was not found on their care file.

A dedicated person was assigned to oversee the maintenance needs of the property with external professionals contacted for specific issues. The format of the centres maintenance log took account of issues that required attention and when they were resolved. The inspectors review of the log found that dates of repairs were not consistently recorded, and it was not clear who tended to repairs. The inspectors recommend that these issues are clearly recorded in the maintenance log.

The centre had a health and safety policy and a site specific and up-to-date safety statement that was appropriately signed by staff and centre and senior management. A nominated staff member held responsibility for conducting monthly audits of the property and health and safety issues with the centre manager having full responsibility for all areas of health and safety. The inspectors found that the health and safety audit tool was broad by design and failed to capture how furnishings, fixtures, equipment items, etc in the individual apartments and the centre were appropriate and in good, safe working order. The inspectors were also informed that weekly checks of the apartments were conducted but records of these were not kept.

It was stated in the health and safety policy that the centre would 'endeavour to have all staff provided with First Aid Responder (FAR)' training which has replaced occupational first aid. Two staff had been FAR trained with remaining staff provided with emergency first aid training. A first aid risk assessment had not been completed that would indicate a sufficient number of staff that would require FAR training. First aid boxes were located in the staff cabin and in the centre vehicles. Procedures for accident reporting were included in the safety statement and it was found that no accidents had occurred since the last ACIMS inspection.

The centre's three vehicles were driven by staff who were legally licenced to drive the vehicles and evidence of tax, appropriate insurance and regular servicing was provided during the inspection. Two identified staff members had responsibility for

conducting monthly vehicle checks. As the checklists were not completed in full the inspectors could not determine if issues identified had been followed up. The inspectors spoke onsite with the centre manager who confirmed that all issues had been addressed. The inspectors recommend that the centre manager demonstrates greater oversight over vehicle safety arrangements.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **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 2.3**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required

- The director of services must ensure that fire safety drills are carried out in line with operating policy with one to take place during the hours of darkness. The procedure for accounting for each young person and staff on the premises must be implemented in full. Risk assessments must be completed if required.
- To assess the implementation of the health and safety statement the DOS and centre manager must strengthen the current health and safety arrangements to assure the safety, health and welfare of the young people and staff residing and working in the centre.
- The director of services must be satisfied that an appropriate number of staff are trained in First Aid Responder.

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 had been no change in centre manager since the last ACIMS inspection. The inspectors found that they as the appointed person in charge of the centre had a good understanding of their role in the operational running of the centre and was committed to ensuring good care practices were being implemented. They were motivated to leading the staff team in the delivery of good care and support to the young people and responding to the young people's individual needs. This was being achieved through their presence at handover meetings, regular team meetings, staff supervision and their ongoing presence in the centre Monday to Friday working normal office hours. In interview with the inspectors the centre manager demonstrated how they performed their roles and responsibilities and of how they were continuing to towards improving practices in the centre. They identified that the centre's training needs analysis required further development to ensure it captured training needs more accurately. The inspectors agreed that this was an area that required improvement. They also demonstrated improvements in practice in response to corrective and preventative actions (CAPA) issued at the last ACIMS inspection. Staff in interview spoke of the ongoing leadership and direction provided by the centre manager. A social worker in interview acknowledged the work of the centre manager and staff in responding to and providing good care and support to the young person they were appointed to. The inspectors found this too in their interviews with staff where they spoke confidently in how they delivered care practices in a child centred manner. Two young people indicated in their questionnaire that staff were easy to talk to, that they listened to them and helped them make important decisions.

The centre manager reported to the DOS as their line manager and kept them informed of what was happening for the young people. This was through ongoing phone contact; supervision, DOS visits to the centre and biweekly formal handover records provided by the centre manager. The inspectors recommend that consideration is given to strengthening the handover record to give the DOS a clearer

understanding on areas relating to the operational running of centre for example staff training and supervision and further include a section to capture the DOS feedback. It was outlined in centre policy that two themes of the national standards would be audited on a bi-monthly basis. Since October 2023 a total of three audits were conducted that examined three themes in total which is not in compliance with centre policy. The three audits were individually undertaken by the centre manager, a peer from the organisations sister centre and the DOS. On review of the audits the inspectors could not determine how the criteria within the standards were deemed compliant and on review of the accompanying action plans they could not determine if some actions included in the plan had been met/completed.

An uptodate service level agreement contract extension was in place between the centre and the Tusla with reports submitted by the centre as required.

The centres suite of policies and procedures had been reviewed and amended by the DOC on four occasions since October 2023. These included amendments to the child protection and safeguarding and data protection and General Data Protection Regulation (GDPR) policies. The DOS informed the inspectors that an escalation policy had been developed in response to a recent inspection of a sister centre within the organisation. Within the policy four types of incidents were named and the accompanying escalation procedures to follow. These related to behavioural incidents, health emergencies, staffing concerns and maintenance issues. The policy lacked detail of how matters regarding the individual care of the young people would be escalated and this is something the DOS needs to include in their next review of the policy document.

The centre had a risk management policy in place that included guidance on the identification, assessment and management of risk. It was the inspectors findings that a more effective approach to risk management was required as management and staff practices were found to not fully comply with the procedures outlined in the risk management policy. For example, the steps recorded in the risk assessment process were unclear with the review and evaluation sections not completed on a sample reviewed by the inspectors. There was no clear separation between individual absent management plans (IAMP's), risk assessments and safety plans as the steps to be taken were the same across the three records. Those interviewed were not able to distinguish between these either. Another finding was that the risk assessment matrix outlined in the centre risk register differed to that utilised in the individual risk assessments. The inspectors found that for one young person the assessed risk rating did not correspond with their presenting behaviour. There were inconsistencies in the risks entered in the organisational risk register and the centre risk register with deficits found in the monitoring of the risks in the registers too.

Lastly, the inspectors identified two risks that were not entered on the centre risk register nor were risk assessments held on the young peoples files.

The centres internal management structure that comprised of a deputy manager and four social care leaders was appropriate to the purpose of the centre. The deputy manager acted up in the centre manager's absence. The various delegation of tasks records in place were specific to the roles allocated to individual staff members for example health and safety officer, training officer and keyworking.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required

- The director of services must carry out their function more comprehensively regarding the implementation of auditing arrangements and oversight of centre practices to continually work towards improving the safety and quality of care and support provided to the young people.
- The director of services and centre manager must conduct a review of risk management arrangements to ensure that clear risk identification, assessment and management processes are in place. To support the implementation of good quality risk management practices centre management and staff must be provided with relevant training.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The director of services must ensure that fire safety drills are carried out in line with operating policy with one to take place during the hours of darkness. The procedure for accounting for each young person and staff on the premises must be implemented in full. Risk assessments must be conducted if required.	On the 02/09/24 the DOS and centre manager reviewed the fire safety policy and health & safety statement (see attached appendix 1.1). A night time fire drill took place on 11/09/2024 (see attached appendixes 1.2) and was appropriately recorded. Risk assessments will be completed as per updated policy if a young person does not engage in drills, which may also inform PEEPs (attached, appendix 1.3).	The centre manager will plan ahead in selecting quarterly dates for fire drills, documenting for the year in advance (next quarterly fire drill to take place week commencing 16/12/2024). Live night staff have been allocated the responsibility of carrying out at least four night drills in the year. The centre manager will oversee this. Also, fire drills will be run during the admission of a yp and/or when a new staff member is being inducted. The DOS will ensure fire drills are carried out as per policy by requesting evidence of same at quarterly intervals, and where policy requires it outside of this.
	To assess the implementation of the health and safety statement the DOS and centre manager must strengthen the current health and safety arrangements to assure the safety,	The DOS and centre manager have developed a more robust health and safety auditing tool which has been implemented since 17/09/2024 (see attached, appendix 2.2). Maintenance records contained	The centre manager will review the new health and safety auditing tool weekly. Monthly health and safety meetings will take place between centre manager and health and safety officer post audit.

	health and welfare of the young people and staff residing and working in the centre. The director of services must be satisfied that an appropriate number of staff are trained in First Aid Responder.	within attached relate to health and safety checks carried out the previous week. The DOS is satisfied that all staff in the centre have basic first aid training. Our risk assessment factors in that the unit is five mins from the nearest hospital. Considering the inspector's recommendation and in the interest of strengthening current health and safety arrangements FAR training services (17/09/2024 – see 3.1) have been contacted with a view to having internal management and live night staff trained in FAR. This will ensure 140 hours of FAR trained cover on the weekly roster.	Monthly audit report will be sent to the DOS by centre manager each month for their oversight. FAR training will be rolled out on a phased basis between September 2024 and May 2025 with an aim to have over 50% of the team trained in FAR. The DOS will ensure that an appropriate number of staff will be FAR trained at all times thereafter
5	The director of services must carry out their function more comprehensively regarding the implementation of auditing arrangements and oversight of centre practices to continually work towards improving the safety and quality of care and support provided to the young people.	The DOS acknowledges that auditing schedule was not maintained in line with operating policy in 2024. This came as a result of crisis presenting within the organisation. On 17/09/2024 contact was made with external professionals who can provide auditing services to the centre where gaps present (see attached – 4.1).	An auditing schedule to be set for 2025 at upcoming manager's meeting 23/09/2024. External auditors will not replace our internal audits however will be used where gaps arise. (see 4.2 attached SCI doc). The DOS will ensure external auditor is assigned takeover auditing duty if and when crisis leads to senior management

	The director of services and centre manager must conduct a review of risk management arrangements to ensure that clear risk identification, assessment and management processes are in place. To support the implementation of good quality risk management practices centre management and staff must be provided with relevant training.	Thorough discussion on risk management protocol held during a team meeting on 12/09/2024 (see attached – 5.1).	being unable to fulfil same. Managing risk and completing risk assessment training is booked for 05/11/2024 (see 5.2 attached) and will run annually for staff with a view to refreshing knowledge and systems in place. The DOS has liaised with SCI external expertise who will attend a risk management meeting in November 2024 with Rainbows Senior Management Teams – with a view to enhancing current risk management processes and linking all current systems together.