An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 134

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Positive Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**21st, 22nd & 23rd September 2021**
Registration Status:	**Registered from the 22nd of January 2021 to the 22nd of January 2024**
Inspection Team:	**Paschal McMahon** **Joanne Cogley**
Date Report Issued:	**30th 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 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 January 2018. At the time of this inspection the centre was in its second registration and in year one of the cycle. The centre was registered without conditions from the 22nd of January 2021 to the 22nd of January 2024.

The centre was registered to accommodate three 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 two young people resident in the centre at the time of the inspection. The centre was granted derogation to accommodate one of the young people as they were under thirteen years of age on admission.

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 27th of October 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 27th of October2021. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed. Following the receipt of the CAPA and additional evidence, inspectors were satisfied that sufficient action had been taken by the centre to address issues raised in the report. As such, each of the regulations examined were then deemed to be met.

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: 134 without attached conditions from the 22nd of January 2021 to the 22nd of January 2024 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.

At the time of inspection one of the two young people in residence had an up-to-date care plan on file in line with the regulations. The second young person was placed under derogation to the statement of purpose as they were under 13 years of age. There was a requirement under the *National Policy in Relation to the Placement of Children Aged 12 Years and Under in the Care or Custody of the Health Service Executive* to hold monthly child in care statutory review meetings. This was also a requirement for the continued approval of derogation. Inspectors found that these statutory reviews had not taken place in line with the requirements of the national policy as the Tusla social worker department had not convened the monthly review meetings as required. Inspectors found that there were no care plans on file for April and July 2021 and a review planned for August 2021 was rescheduled to September 2021. There was evidence on file that the centre manager and the regional manager had contacted the relevant social work department requesting that care plan meetings take place and seeking updated care plans

The inspectors found that the young people were encouraged to attend their statutory review meetings and had completed child in care review forms, and this was confirmed to inspectors by a young person in interview. There was also evidence in statutory care plan review minutes that, where appropriate, parents had participated in the review meetings and had an input in decisions made.

Each young person had an up-to-date placement plan on file covering a three- month period which outlined the current issues, individual needs and the supports required to implement the goals of the care plan. Social workers confirmed that they were provided with copies of the placement plans and there was evidence that the views of parent's were accommodated where possible. Key working plans based on the goals of the placement plans had been developed and there was evidence of regular key working being undertaken with both young people at the time of inspection.

Inspectors found that the young people had access to external support services including counselling and efforts were being made to access additional specialist services the young people required such as equine therapy and CAMHS. There was evidence on records that the organisations psychologist had provided clinical guidance and support to the staff team including training in the centre's model of care and developing therapeutic plans for the young people.

Inspectors reviewed care files, staff questionnaires and spoke with the social workers, management and staff in the centre and found there to be effective communication overall between all parties.

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.

All staff had been trained in a recognised model of behaviour management and there was evidence of regular refresher training being completed. There had been a delay in some staff receiving the physical aspect of the training due to Covid 19 however all staff had received the training at the time of inspection.

Each young person had an individual crisis management plan (ICMP) on file which outlined safety concerns, current risks, preventative measures, triggers and de-

escalation strategies and had been reviewed regularly. Consequence records showed that positive behaviour was rewarded and that appropriate consequences were only applied for unacceptable conduct. There was evidence on file that individual work had been completed with young people following incidents to get them to understand and manage their own behaviour. There were examples of good practice such as in one case where two young people engaged in a successful mediation process facilitated by staff following an incident and efforts had been made to address bullying with the young people through individual work and at house meetings.

Inspectors found that while there was evidence of a positive approach to the management of behaviour and a low level of incidents in the centre not all incidents had been well managed. It was evident from interviews and records that there was a negative dynamic between the young people in the centre at times and the staff team had experienced difficulties in managing the young people's behaviour. The inspectors found that there were a number of serious incidents that occurred involving one young person which were not managed effectively and led to the unplanned discharge of the young person. These incidents took place in June 2021. The young person subsequently engaged in a number of serious incidents over a three-day period including damage to property/unit cars, fire setting and threats of suicide and self-harm. During these incidents the Gardai were called on three occasions to manage the situation and the young person was taken to hospital on two occasions due to concerns relating to their mental health. The young person was subsequently discharged to one of the organisation's other centres due to their high-risk behaviours and the risks posed to the other residents.

An organisational review of these incidents identified several concerns in relation to the management of these incidents including the failure to follow the strategies outlined in the young person's individual crisis management plan, the failure to manage the environment and the overreliance on the use of the Gardai in managing the young person's behaviour. The review also highlighted the fact that several staff members the young person had developed close relationships had left the centre in the previous months which also had a negative impact on the young person and this issue is discussed in more detail under section 6.1 of this report. Senior management must ensure that the team's behaviour management approach is closely monitored to ensure that the learning outcomes identified in recent incident reviews are implemented. This should be reviewed through the regional managers forum.

There was evidence on file that social workers for young people had provided sufficient pre-admission referral information to the centre and pre-admission risk

assessments had been undertaken to identify and address areas of vulnerability for young people.

Inspectors found that the centre manager conducted a monthly review of incidents in the centre. These provided an overview of significant events, restraints, and identified patterns and learning outcomes. Personnel external to the centre including the regional manager also conducted monthly audits which included a review of the centre's approach to managing behaviour.

There were agreed restrictive practices in place to ensure safety. Restrictive practices were monitored and reviewed as necessary and in line with the young people's individual risk management plans. There was also evidence in centre audits that restrictive procedures had been reviewed.

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

From a review of questionnaires and interviews with staff it was evident that there was an open culture whereby staff could raise concerns and they expressed confidence in the centre management. Young people in interview were aware of the centres complaints process and there was significant evidence of young people using the process to resolve issues. There was also evidence that the young people had accessed their records and had been informed of their rights at house meetings. There were opportunities for the children, their families and social workers to provide feedback on the care provided and to identify areas for improvement and this was evident in the minutes of care plan reviews and professionals' meetings. The centre maintained appropriate contact with families through telephone contact and facilitating family access visits.

The centre had a policy on the notification, management and review of incidents and inspectors were informed by allocated social workers that incidents were reported in a prompt manner both via phone and e-mail. All incidents that took place were reviewed and commented on by the centre and regional managers. 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 which included the managers, senior management and where appropriate the organisation's behaviour management trainer and psychologist. Staff in interview were able to identify learning outcomes from the most serious incidents that occurred in the centre in June 2021 referred to earlier in

the report. The incident had also been reviewed at a team meeting and the organisation's behaviour management trainer had also met with the staff team to review the young person's ICMP and the team's behaviour management approach.

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

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

Actions required

- Senior management must ensure that the teams behaviour management approach is closely monitored to ensure that the learning outcomes identified in recent incident reviews are implemented. This should be reviewed through the regional managers forum.

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 a management structure in place with clearly defined lines of authority and accountability. In questionnaires and interviews staff reported they were confident in the leadership of the centre and that they provided them with good guidance and support.

There were clearly defined governance structures in place. The centre manager was on site five days a week, had overall responsibility and accountability for the delivery of care and there was evidence of their oversight in centre records and audits. The manager reported to a regional manager who had visited the centre on a regular basis to review records, conduct audits, and they also met with staff and the young people.

They had access to all information generated in the centre on the organisation's IT system and had attended occasional handovers and team meetings.

There was a culture of learning in the centre which was evident across a range of records including team meetings and a number of well-developed auditing systems. There were two quarterly quality assurance audits carried out by the organisation's auditors in 2021 which assessed the centres compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). The areas that required action included the requirement for management to ensure that all documentation is kept updated and sufficiently detailed along with improvements in recording and evidencing of work completed. The inspectors were provided with evidence that centre management had implemented action plans to address these deficits.

One of the governance mechanisms in place was a weekly link in meeting between the manager, senior management, and other managers in the region. Inspectors reviewed a sample of these meeting minutes and noted that the recording varied in quality as some minutes were more a recording of statistics with limited discussion recorded while others were more comprehensive. The sample of minutes reviewed did not allow inspectors to make a judgement on whether this was an effective governance mechanism based on samples provided and recommend that detailed minutes of all these meetings are recorded going forward.

The registered provider and the client services manager liaised with Tusla's national private placement team (NPPT) in relation to placement contracts and procurement of services. The centre was operating under an old service level agreement while negotiations about contracting took place. There were regular meetings and updates regarding young people's progress and an annual report was submitted to NPPT.

The inspectors reviewed a number the policies and procedures during the inspection and found that these were in compliance 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 were provided with training on policies and procedures during induction and there was evidence that policies and procedures had been reviewed at team meetings.

There was a risk management framework in place for the identification assessment and management of risk. Staff had a good working knowledge of the system and risk management was an agenda item at team and management meetings. Risk registers were in place to facilitate tracking and management of risk and a daily risk review and governance report was completed by the regional manager. There was evidence from a review of young people's individual risk management plans (IRMPs) that individual risks were being identified and managed. The organisation had an on-call

system in place to support staff at all times in managing incidents and risks in the centre.

Inspectors found that there were protocols and procedures in place for the management of the Covid-19 virus. Plans were in place to manage visitors coming to the centre. All visitors were required to complete a questionnaire confirming that they were not displaying symptoms of Covid 19, temperature checks were conducted prior to entry and there was a requirement to wear masks. Staff interviewed confirmed the centre had adequate supplies of anti-bacterial products, hygiene equipment, personal protective equipment and that there had been no cases of Covid 19 in the centre.

There was an internal management structure appropriate to the size and purpose of the centre. This had been strengthened prior to the inspection with the appointment of two additional social care leaders to comply with the staffing requirements of the Tusla national private placement team. The deputy manager assumed responsibility for the centre in the manager's absence. Inspectors viewed a delegation record which detailed tasks to be completed in the manager's absence along with a specific task list for each member of staff. The centre manager maintained a written record of managerial duties being delegated to members of staff detailing their responsibilities and designated tasks.

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

Compliance with standards	
Practices met the required standard	**Standard 5.2**
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 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.

There was evidence in management meetings and centre audits that workforce planning took place and that staffing requirements were under constant review at a regional and centre level. The centre staff team comprised of a manager, deputy manager, three social care leaders and seven social care workers. Inspectors were satisfied from a review of personnel records that the centre had the minimum required number of social care qualified staff. The centre had two relief staff and managers informed inspectors that there was a plan to recruit additional relief staff. The registered provider must ensure that the centre has a sufficient number of relief staff to cover all forms of leave.

The roster system in place in the centre provided for three staff on shift each day. Inspectors noted from a review of rosters that there were a number of months in the year prior to inspection when the centre did not meet this requirement. For example, in February 2021 when there were three young people resident, there were five days in the month when there were only two staff on shift, four days with two staff and a trainee social care worker and nine days when the deputy manager was on shift with two staff members.

Inspectors found that there had been a very high staff turnover since the last inspection in August 2020 with only two of the ten staff still in post along with the deputy and centre manager. During this thirteen month period there were ten staff who left their posts including two staff transferring to the organisation's other centres and two staff returning to the relief panel. Eight of the current team were appointed in 2021. Three of these were social care leaders and were experienced in residential care however inspectors reviewed seven personnel files of staff who had been appointed in 2021, some of whom had since left their posts and found that six of these staff had no residential experience prior to taking up their roles.

Inspectors found that the high staff turnover made it difficult for the centre to realise their agreed purpose and function and to effectively implement their model of care. The high turnover also had a negative impact on the young people in terms of relationship building, the team's ability to manage challenging behaviour and

impacted on their efforts to provide a consistency of care. One of the young people told an inspector that the staff team was constantly changing and as a result it was difficult to build up relationships and in the previous year they had a number of different keyworkers. One of the findings of the incident review following the unplanned discharge of a young person in June 2021 referred to earlier in the report highlighted the fact that "key people" in the young person's life had left the centre and it was easier for them to breakdown their placement. Social workers and a Guardians Ad Litem also identified the lack of consistency as an issue and in one case requested that the centre manager was to be their contact person as they were the one consistent person in the young person's life that they had a long standing positive relationship with and could manage them effectively. Staff turnover was also acknowledged by management as a factor in deficits in placement planning and key working earlier in the year which has since improved after additional training. The registered provider must ensure that they focus their efforts on maintaining a consistent and stable staff team going forward.

While the centre had a number of incentives in place to promote staff retention these measures had not been effective. These measures included incremental pay scales for social care workers, healthcare provision, a pension scheme and an employee assistance programme. Inspectors found it difficult to ascertain the reasons for staff leaving their posts as there was only one exit interview presented for review even though six staff had moved on from the service in the previous thirteen months. The client service manager must ensure that every effort is made to conduct exit interviews with staff leaving the service to analyse the reasons why staff have left their posts.

The centre had a formalised procedure for on-call arrangements at evenings and weekends.

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

The organisation had a staff and education policy and their own online training portal. Training for staff was co-ordinated centrally by the organisation and there was a training calendar in place. From a review of the training records and a sample of the personnel files, inspectors found that mandatory training for staff was in date except for a number of staff requiring policies and procedures training and the practical element of first aid and this training was scheduled. There was evidence in

questionnaires and interviews of staff accessing a wide range of training opportunities in addition to the core training.

The centre had a formal induction process. All staff in the centre receive induction training on commencement of employment followed by a centre specific induction process. There was written evidence of induction on personnel files and staff members interviewed as part of the inspection process confirmed they had received both an organisational and house specific induction.

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 7**
Regulation not met	**None Identified**

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

Actions required

- The registered provider must ensure that the centre has a sufficient number of relief staff to cover all forms of leave.
- The registered provider must ensure that they focus their efforts on maintaining a consistent and stable staff team going forward.
- Senior management should conduct exit interviews with staff leaving the centre to analyse the reasons why staff have left their posts.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	N/A		
3	Senior management must ensure that the teams behaviour management approach is closely monitored to ensure that the learning outcomes identified in recent incident reviews are implemented. This should be reviewed through the regional managers forum.	A SERG review took place after the incidents and the learnings were shared with the team as part of a team review and through team meeting forums and individual supervisions. This remains a focus for the centre with the Regional Manager daily risk report and regional governance report and is closely monitored in this forum.	Learnings from any SERG reviews or incidents in the organisation are reviewed and discussed weekly in the weekly link in forum across all services. This can be then evidenced in discussions in team meetings in services with staff teams. Regional Managers continue to provide daily oversight with regards to any significant events paying particular attention to the risk rating. The organisation has changed its risk framework to reflect the following: Any incidents over 10 require a team incident review at a local level, any incidents 15+ require a SERG review and any incidents over 20 are escalated to SMT for review.
5	N/A		
6	The registered provider must ensure that the centre has a sufficient number of relief staff to cover all forms of leave.	The organisation operates its own internal relief panel. Each centre also has their own pool of regular relief staff of 2/3 people	The organisation has an ongoing recruitment campaign to increase the numbers on the relief list monthly.

		whom they try to use consistently for continuity of care. Annual leave is planned as per policy in advance, allowing for preplanning of the rosters for relief staff required and monitored by the HR department, so it is evenly planned throughout the year.	Interviews are held every 2 weeks in the organisation for these roles. The organisation will endeavour to continue to build this panel. Currently we are recruiting for an additional full time permanent contract per service to have an excess of staff where any types of leave can be catered for by this excess.
	The registered provider must ensure that every effort is made to maintain a consistent staff team in the centre.	We acknowledge that turnover has been high in the centre in the past 12 months. However, we have a fully contracted, stable and consistent staff team with an appropriate skill mix and experience levels in place.	The organisation has implemented incentives to support staff retention with the introduction of pay scales, healthcare provision and pensions. An ongoing emphasis will be placed on supports in services, training, supports and communication with staff teams as well as senior management presence in the service to ensure that staff feel secure in their roles and supported.
	Senior management should conduct exit interviews with staff leaving the centre to analyse the reasons why staff have left their post.	It is our policy that any staff leavers in the organisation are contacted to conduct an exit interview prior to their last day to ascertain any learning for the organisation	The organisation will endeavour to promote engagement in the exit interview process and act promptly in the notice periods of any leavers to ensure feedback

		positive or negative that can be utilised for future development or quality improvement. These exit interviews are now conducted by our regional management team.	and organisational learning is obtained.