An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 177**

**Year: 2024**

# Inspection Report

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| **Year:** | **2024** |
| **Name of Organisation:** | **Pathways Ireland Ltd** |
| **Registered Capacity:** | **Three young people** |
| **Type of Inspection:** | **Announced** |
| **Date of inspection:** | **20th and 21st of August 2024** |
| **Registration Status:** | **Registered from the 23rd of September 2023 to the 23rd of September 2026** |
| **Inspection Team:** | **Eileen Woods**<br>**Catherine Hanly** |
| **Date Report Issued:** | **21st 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 23rd of September 2020. At the time of this inspection the centre was in its second registration and was in year one of the cycle. The centre was registered without attached conditions from the 23rd of September 2023 to the 23rd of September 2026.

The centre was registered to provide care for three young people on a medium to long term basis. The centre worked within an outcomes based model of care with the goal to have the young people at the core of that work. The approach was to be person centred, trauma informed and for this to take place within a homely environment. There were three children living in the centre at the time of the inspection.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| 1: Child-centred Care and Support | 1.3 |
| 3: Safe Care and Support | 3.2 |
| 7: Use of Resources | 7.1 |

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 18th 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 25th of September 2024. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 177 without attached conditions from the 23rd of September 2023 to the 23rd of September 2026 pursuant to Part VIII, 1991 Child Care Act.

## 3. Inspection Findings

**Regulation 5: Care Practices and Operational Policies**
**Regulation 9: Access Arrangements**
**Regulation 11: Religion**
**Regulation 17: Records**

**Theme 1: Child-centred Care and Support**

**Standard 1.3 Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.**

This centre had a number of different ways in place for the young people to be, in the first instance, aware of the types of planning and records created and, secondly, to be part of shaping the daily routines and the overall goals of their placement. Inspectors found that on a weekly and monthly basis formal consultation took place, these were completed by the young people and the staff in as natural a manner as was possible. This resulted in the young people being aware of an area of discussion or education that might be coming up, having agreed it with their key worker in their monthly consultations. The young people were offered opportunities to read their records at the centre and there was a young person's booklet available to them. One young person could not recall the booklet and noted that they would like more information on their rights within the centre. Inspectors recommend that the young persons booklet is gone through again with young people.

The young people had been informed of Tell Us the Tusla complaints and feedback procedure, they were aware of empowering young people in care, EPIC, the advocacy organisation for young people in care. EPIC advocates had been invited to and had visited the centre to meet the young people and brought information for the young people to read. The young people's booklet also had contact information relating to these services and to the Ombudsman for Children office.

The young people had contributed to or attended their child in care reviews. Additional meetings had been sought and facilitated, with all professionals, at a young person's request. The young people were encouraged and supported to contact their social workers about relevant matters and decisions. One social worker told inspectors about their visits to the centre and contact with the young person who they observed to be settled and well cared for at the centre. The young person had also

told them that they felt good about living at this centre long term. Two social workers told inspectors that they had observed the centre to be a place of safety and of significant progression for the young people.

The young people had house meetings every week, inspectors could see where items had been brought to the staff meeting from the house meeting. The centre manager was reading and responding to the young peoples meeting records and engaging positively with the content. Inspectors did find that it was difficult to discern which young people had attended in person, in what numbers and how the meetings were conducted. These records should be clear about these aspects as it supports not just good house communication but also reflects the centre group dynamic and how that functions for all young people.

Each of the young people had a key worker, one young person said in their questionnaire that they meet with their key worker and were aware of their placement plan. Inspectors could see on all the young people's files that they met their key workers regularly. Inspectors met with two young people as well as receiving questionnaires back from two also. During their conversation with inspectors two young people expressed dissatisfaction with how they felt staff responded to their issues specifically about fairness within the house and how staff heard their concerns and acted on them. The young people raised examples to explain how and why they believed this to be the case, in the case of one of their example's inspectors could not initially find an account of this on file. A record of aspects relating to the described event was later provided to inspectors.

Inspectors found that the centre group dynamic had been a recurring issue, one care plan record suggested that this was a theme back to 2023. The centre management and staff had changed significantly with a new centre manager and deputy commencing in post during April and May 2024. They addressed each of the comments regarding fairness or conflict between young people through internal complaints processes, risk assessments, anti bullying education and offered mediation. The young people had been offered meetings with the service manager and one had taken up that offer. Inspectors could see therefore that action had been taken, responding to each situation, however found that there was an over reliance on the informal complaints process and a lack of evidence of tracking of trends. The specific event referenced above and the description given by the young people of what followed that event was new information for the centre management and they committed to following up on this. The matter of the comments about staff fairness and decision making was brought by inspectors to the centre manager. The centre

manager formalised the young people's concerns into a complaint, notified it to social workers and escalated it to the service director who initiated an investigation immediately. The two young people were made aware of this and of what would happen next. Upon a return visit to the centre by an inspector several days later a record of the event in question was printed off and available for review. The young people were engaged in active follow up on the matters they had raised. These were brought to a conclusion through a complaints process by the time of this draft report. The external management had ensured that they followed up with the young people following the investigation to give feedback and to ask if they were feeling happy with the final outcomes.

| Compliance with Regulations | |
|---|---|
| **Regulation met** | **Regulation 5**<br>**Regulation 9**<br>**Regulation 17** |
| **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 1.3** |
| **Practices did not meet the required standard** | **Not all standards under this theme were assessed** |

**Actions required**

- The centre manager and the senior management team must ensure that they consult with the young people and review how they track trends in how comments and complaints are identified and managed in their ongoing support of young people's rights.

## Regulation 5: Care Practices and Operational Policies
## Regulation 16: Notification of Significant Events

## Theme 3: Safe Care and Support

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

The centre is part of an organisation with a model of care and clinical process that supports a positive outcomes approach to care. The staff team and management had

all received training in the model of care and in the organisations preferred approach to managing challenging behaviour. Inspectors found that working knowledge of how the positive behaviour support operated day to day was still at an emerging stage with the new team. In support of the teams ongoing development the model of care was discussed at team meeting and inspectors recommend that the team highlight how the model supports and promotes positive change on an ongoing basis.

Inspectors also found evidence of the clinical psychotherapeutic consultant providing focused training and resources to then be implemented by the team in support of the young peoples needs. These interventions had a positive measurable impact over time based on feedback received by inspectors from staff and from external persons. Examples of materials provided included areas such as the window of tolerance, exploration of conversations using a therapeutic lens and mindfulness. These were stored on clinical folders along with a clinical progression tool that the team completed and provided to the consultant. They then met with the teams to provide insight and support. The staff and management informed inspectors that they could also contact the consultant for interim advice.

Inspectors found that there were person centred progression logs completed by staff, usually the key worker, to be then provided to the clinical consultant as a means to target the work. The rotation was three monthly, with interim monthly updates. In the young people's key work and one to one work folders there was some evidence of resourced key work taking place, but also some gaps for example related to a recent diagnosis a young person received. The clinical records had incomplete documents relating to the clinical consultation and therapeutic care forms and this should be kept under review and updated appropriately. Upon review of the progression logs it was evident that the process worked best when the information provided was as up to date as possible, for example, where a centre group dynamic was changing.

Inspectors found that the team were engaged with the therapeutic process and introducing areas for key work and individual work following discussion with the young people. The staff team and key workers have a range of weekly and monthly planners that they have to complete. Inspectors found that whilst placement plans and goals were reviewed monthly that the trackers were not being updated, whether this related to daily routines, monthly goals or weekly reports, this was an area of ongoing team development.

The young people were all attending external professionals and had clinical appointments and supports. They were supported to attend these appointments and

there was evidence of communication with the therapists involved relating to some feedback. This was done with young people's awareness and permission where appropriate. The team ensured that they accompanied the young people to their appointments and were available to them afterward should they need support.

The centre files contained a range of plans related to behaviours, these included individual crisis support plans, behaviour support plans and absence management plans. There were also safety plans and risk assessments on file. Inspectors found that there were monthly review routines in place for these. The quality was generally good but some displayed a lack of tracked review for learning purposes. Staff were not signing to indicate if they had read these and other plans and inspectors did not see evidence of these handed over in detail at handovers and team meetings.

The process around the behaviour management plans did not present evidence of being linked to a wider review process that supported tracking of trends and analysis of effectiveness. There were good existing structures related to centre based review following significant events, these were per event. There was also an organisational significant event review process that worked on a thematic basis and whilst being very good it did not contain evidence of supported tracking of trends in accumulating comments and complaints emanating from the centre.

Inspectors found therefore that whilst the centre were responding, assessing and developing plans, including anti bullying and therapeutic interventions that based on the evidence reviewed by inspectors the effectiveness and relevance of these was impacted by standards of reporting and recording, staff experience and a system, although robust, that didn't allow for tracking trends in all types of complaints and how the responses were effective or not.

The organisations compliance and practice manager and the service manager had completed an audit of the centre two weeks before the inspection and this included a review of this standard related to positive behaviour support. They had identified areas of strengths and needs and created a series of actions for the centre to respond to.

The centre had a policy on restrictive practice and records were maintained at the centre in respect of each young person and the restrictive interventions in place. Some were shared and others specific to that young person. These were reviewed monthly and reflected the views of the social workers and in some instances the wishes of the young person. Inspectors found that the non routine restrictions listed

on the policy and in place at the centre were not fully reflected on the restrictive practice records and require that these be reviewed. Additional centre restrictions were noted by inspectors and referenced by young people who identified that they were not fully sure why they were in place, these related to locking of certain areas of the house at night and the locking of the utility room during the day.

| Compliance with Regulation | |
|---|---|
| **Regulation met** | **Regulation 5**<br>**Regulation 16** |
| **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 3.2** |
| **Practices did not meet the required standard** | **Not all standards under this theme were assessed** |

**Actions required**

- The centre management and staff must oversee the clinical folders to ensure that they are up to date and contain the resources provided by the consultant in relation to each young person.
- The centre management must review the restrictive practices and how they are recorded to accurately capture the non-routine restrictive interventions in place. Young people's views should be reflected in review of those.
- The centre management must ensure that improvements take place in standards of recording, reporting, signing off and printing for the files. This must be supported by effective internal audit and team development.

## Regulation 7: Staffing

### Theme 7: Use of Resources

**Standard 7.1 Residential centres plan and manage the use of available resources to deliver child-centred, safe and effective care and support.**

Inspectors found that as a key resource in the care of the young people and an environment for staff to work within that the centre required a focused and specific development plan for the physical premises. There were unclean and not fully

operational bathrooms, damage to the kitchen cabinets, damaged fittings and carpets along with some items of furniture that required replacement or improvement. There had been painting and improvements in some areas of the house and it was the new managements intention to make the house more homely throughout. The evidence of this was present but this had not involved a full property review. Following the inspection the service senior management team visited the centre and put together a series of improvements to ensure that cleaning was upgraded, and repairs completed. Written and photographic evidence of works completed to date was provided to the inspectorate before this draft report along with a list of remaining items planned.

A young person noted to inspectors that sometimes they had to go places related to another young person because there were no staff at the house that they could stay with, daily logs supported that this had occurred. Inspectors could not find reliable information across the handovers and daily logs recently in respect of who was on duty and how many were on duty. The manager stated that the structure of the roster was to have three staff daily, seven days a week, and that the centre management can assist if needed Monday to Friday. The risk assessments and behaviour support plans related to the group dynamic, on two of the files, focused on having each young person on a separate routine and fully supervised whilst at the centre. Some staff recorded the information well in relation to the schedules and supervision within the centre and others did not add as much detail. The centre records must improve in relation to staffing levels and in relation to the routines and supervision of the group.

The staff team consisted of a centre manager, a deputy manager and eight full time staff in post at the time of the inspection. A review by inspectors of the available documents showed that on average 10 or more dates out of each month had two staff and not three staff listed, these varied between week days and weekends. It is important that where specific staffing levels are seen as needed and are committed to that these then be accounted for. The centre manager must ensure that they keep track of gaps, who is covering those gaps and evidence this in follow up with their line management.

The centre management team maintained records of petty cash and tracked spending on groceries, money for young people and other expenses. The records on each young person's file did not give a strong picture of their clothing money and how well this functioned for them. The management should consider clarifying those records so that the adequacy of this can be tracked. The young people were evidenced as well resourced for courses and with the equipment they needed for those courses, for their

second level education and their chosen activities. The centre manager noted that the team and young people try to recycle and are engaged in the national return scheme.

Family access was organised and agreed with the social workers depending on the legal status and other factors. The young people's point of view was reflected in the records also and there were active plans in place for changing and evolving family dynamics.

| Compliance with Regulation | |
|---|---|
| **Regulation met** | **Regulation 7** |
| **Regulation not met** | **None identified** |

| Compliance with standards | |
|---|---|
| **Practices met the required standard** | **Not applicable** |
| **Practices met the required standard in some respects only** | **Standard 7.1** |
| **Practices did not meet the required standard** | **Not applicable** |

**Actions required**

- The registered provider must ensure that they have effective property and maintenance systems in place on an ongoing basis.
- The centre manager and their line management must ensure that they track and account for the staffing levels and who is undertaking those shifts in a manner that is linked to planning, safe care and consistency. They must evidence corrective actions taken where deficits do occur.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| 1 | The centre manager and the senior management team must ensure that they consult with the young people and review how they track trends in how comments and complaints are identified and managed in their ongoing support of young people's rights. | The centre management team have completed a full review of complaints made by the young people to ensure that all trends have been captured and responded to. The Compliance and Complaints Officers meets with young people during audit visits to discuss their experience of living in the centre where possible. The centre conducted a review of the complaints policies at the team meeting on the 3rd of September 2024 to ensure that all care team members are fully aware of same. | The centre management will complete a full review of all complaints monthly to identify trends and patterns. All non-notified complaints that have been made 3 times over the previous 3 months will be escalated to a notified complaint.<br>The Complaints and Compliance Officer will monitor complaints in the centre and will continue to consult with young people during regular audits.<br>The Operations Manager will consult with young people during monthly visits to the centre to ensure that they are being supported with their rights. |
| 3 | The centre management and staff must oversee the clinical folders to ensure that they are up to date and contain the resources provided by the consultant in relation to each young person. | The centre management team reviewed all clinical folders on 29th of August 2024 and added the required resources provided by the CSP for Pathways Ireland. The requirement to store resources by the CSP was discussed at the team meeting on the | The centre management team will provide oversight to the clinical folders within one week of receiving clinical resources to ensure that they are on file and up to date. This will be reviewed during audits by the CCO on a regular basis. |

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| | | 3rd of September 2024. Keyworkers will ensure that all clinical resources related to the young people are stored in the relevant folders monthly. | |
| | The centre management must review the restrictive practices and how they are recorded to accurately capture the non-routine restrictive interventions in place. Young people's views should be reflected in review of those. | All restrictive practices have been reviewed and updated and any restrictions no longer required have been ceased in the centre as of 29th of August 2024. The centre has developed a system whereby young people are consulted during the implementation and review of restrictive practices and this will be appropriately recorded. The policy on restrictive practices was reviewed by the team at the team meeting on the 19th of September 2024. | The centre management team will review restrictive practices monthly in consultation with the allocated social workers or sooner where required. Restrictive practices are reviewed during visits by senior management and audits by the CCO who will ensure that consultation with young people is evident in implementation and reviews. |
| | The centre management must ensure that improvements take place in standards of recording, reporting, signing off and printing for the files. This must be supported by effective internal audit and team development. | A full review of the recording system in the centre took place on 27th of August 2024 by centre management. The policies on information governance were reviewed at the team meeting on 29th of August 2024 Centre management have devised an in-house training programme to support care team members in meeting their | Centre management and social care leaders will provide daily oversight to records to support improvements to the standards of same. A particular focus will be placed on information governance systems during the induction phase of employment in the centre to support skill development in this area. Senior management will monitor this |

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| | | information governance obligations. This was rolled out with current care team members in the centre on the 19th of September 2024. | during visits to the centre and oversight on the NSS system. |
| 7 | The registered provider must ensure that they have effective property and maintenance systems in place on an ongoing basis.<br><br>The centre manager and their line management must ensure that they track and account for the staffing levels and who is undertaking those shifts in a manner that is linked to planning, safe care and consistency. They must evidence corrective actions taken where deficits do occur. | The registered provider conducted a full review of the property during the week of 2nd of September 2024. There is a full programme of works in place since the purchase of the centre in 2024 enabling works to commence. The shower, fittings and fixtures were repaired by the 3rd of September.<br><br>The centre management team and care team members are now utilising the NSS software system to track all staff hours to ensure staffing levels is appropriate to the needs of the young people in the centre. Completed Thursday 12th of September 2024. | A new maintenance system is currently being developed and will be in situ by the end of Quarter 4 of 2024. The centre management team are continuing to work with the young people to create a homely space in line with their needs and wishes and this has been incorporated into the ongoing programme of works. The management team will provide daily oversight to the cleaning of the centre.<br><br>Daily logs will be reviewed each morning by the centre management team to ensure that staffing and levels of supervision are accurately recorded. This also forms part of the inhouse information governance training with current care team members. Rosters and staffing will be reviewed by the CCO during audits under relevant teams. Weekly staffing meetings take place with senior management and HR to ensure that |

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| | | | the staffing is aligned to the needs of the young people. |