An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 157

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Gateway Organisation**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**24th and 25th November 2020**
Registration Status:	**Registered from 17th June 2019 to 17th June 2022**
Inspection Team:	**Lorraine Egan** **Cora Kelly**
Date Report Issued:	**29th January 2021**

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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

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 17th June 2019. At the time of this inspection the centre was in its first registration and was in year two of a three-year cycle. The centre was registered without attached conditions from the 17th June 2019 to the 17th June 2022.

This centre originally commenced as a single service and subsequently became part of an already established provider of residential care. The centre was registered to provide long term care for up to four young people, male and female, aged between 13 and 17 years of age on admission. The model of care was described as being based on an integrated relationship-based approach which provided a framework for positive interventions with young people which meets their social, emotional, behavioural and therapeutic needs. The centre integrates the circle of courage and three pillars model of care in their work with young people. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
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 and discussed the effectiveness of the care provided. They conducted interviews with senior management, staff and the allocated social workers. 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. This inspection was carried out through a number of telephone interviews and a review of documentation both remotely and onsite.

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 16th December 2020. 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. At the time of the inspection, Regulation 5 in the draft report was deemed not met. The centre manager returned the CAPA on the 30th December 2020 and after communication with them, a revised CAPA was submitted for review on the 15th January 2021. This was deemed to be satisfactory as the inspection service received evidence that the non-compliant regularity issues had been addressed.

Based on 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: 157 without attached conditions from the 17th June 2019 to 17th June 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5 Care practices and operational policies
Regulation 6 (1 and 2) Person in charge

Theme 5: Leadership, Governance and Management

Standard 5.1 - The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The director of services had responsibility for ensuring the centre was operating in compliance with regulations, legislation and the National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors found that while a number of the centre's operational policies had been updated throughout 2020, further improvements were necessary to fully meet the requirements of the national standards. These areas included child safeguarding procedures, complaints policy, risk management systems and the internal and external auditing processes for the assessment of the safety and quality of care provided in the centre.

Centre policy development had been delegated to the centre manager. They also had full responsibility for the regular review of the documents so as to ensure that relevant legislation and national policy were incorporated into the procedures. On completion, the policies were forwarded to the director of service for sign-off. Inspectors were told by the director of service that new arrangements were being introduced to reassign this role to senior management. As part of the amalgamation process with the parent organisation, some governance systems within the centre were currently in a transition phase and a strategy had been developed to support the new arrangements being implemented.

From a review of centre policies, inspectors identified some gaps in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015. Areas that needed further revision included, the mandated reporting procedures, the steps to follow regarding reasonable grounds for concern and the recording of child protection and welfare concerns. The centre had a complaints policy in place which also needed amendment. The risk management policy had yet to be completed which inspectors found had some impact on the way in which risk was identified and managed in the centre. This will be discussed later.

Further, the auditing and governance systems in place were not robust enough to address gaps in compliance with legislation and national policy. However, inspectors were provided with a new quality assurance plan which formed part of the implementation strategy mentioned above. This included the introduction of updated monitoring systems, comprising of a dedicated quality assurance and compliance coordinator. It outlined a clear framework for the roll out of the auditing process within the centre. Timelines for completion were indicated and the monitoring system was aligned with the National Standards for children's Residential Centres, 2018 (HIQA).

From questionnaires and interviews, in general staff had an understanding of aspects of policies and procedures that informed practice in the centre. However, there were gaps in knowledge regarding the standards, the complaints procedure and mandatory reporting procedure. Inspectors saw evidence where some themes in the National Standards for Children's Residential Centres, 2018 (HIQA) had been presented to staff at team meetings.

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-cantered, safe and effective care and support.

The centre manager had been in post seven months prior to the opening of the centre. They had appropriate experience and qualifications for the role including completion of a management course. While some evidence of their leadership was noted on centre records including policies and procedures, monthly reports and communication with social work departments, improvements were required in specific areas such as decision-making and risk management. There were gaps noted by inspectors regarding direction and guidance on team meeting minutes, supervision minutes, safety plans and individual crisis management plans. Regular auditing and monitoring was not taking place which impacted how the centre ensured that the delivery of care was safe and effective for young people in placement.

The centre manager had overall responsibility and authority for the delivery of the service in the centre. They were present in the centre from Monday to Friday and were part of the on-call arrangement. They reported directly to the director of services who also provided them with supervision. The internal management

structure consisted of a deputy manager and three social care leaders and inspectors found that this was appropriate to the size of the organisation.

While centre management informed inspectors that regular internal management meetings were in operation, there was no evidence of minutes being recorded from these discussions. Senior management meetings were also taking place between the director of service, centre manager and deputy manager but these meetings were not held regularly. From the two senior management meeting minutes reviewed by inspectors, deficits included an absence of a consistent agenda and there was limited recording of detail on the discussion of topics.

Inspectors saw evidence that the deputy manager held responsibility for specific tasks which had been delegated to them when the centre manager was absent. However, there was no written record kept of the duties that had been assigned or key decisions made when tasks were devolved from the centre manager. Staff were clear about their roles and responsibilities when working with young people and indicated to inspectors that they were being supported by internal and external management. There was a service level agreement in place between the centre and the funding body with six monthly reviews. A progress report was also submitted as part of the funding process.

From a review of the centre records, inspectors found that there were a number of different risk management frameworks in use for assessing risk in the centre and consequently there were gaps in how risks were being measured. The system in operation included individual crisis management plans (ICMPs), safety plans, absent management plans, impact risk assessments and significant event notifications (SENs). However, deficits were noted in the identification of risk for both young people. Interventions outlined in ICMPs and safety plans were not robust enough and did not adequately address how risks were to be responded to by staff in practice. While there was a policy in place, it was not clear to inspectors how it supported the identification, assessment and management of risk for young people. Staff when interviewed and through questionnaires had some awareness of the various risk processes in practice. However, they will benefit from training on the policy which was planned for early in the new year. The centre maintained an organisation and centre risk register.

Standard 5.3 - The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre's statement of purpose was reviewed in October 2020 and there were plans in place for an annual review as part of the centre's governance arrangements. While the statement in general reflected most of the criteria as outlined in the National Standards for Children's Residential Centres, 2018 (HIQA), it was developed as a suite of comprehensive policies and procedures rather than a description of the model of service provision delivered by the centre. There were no versions of the statement available in information booklets for young people, family members or social workers. Social workers were not familiar with the statement and said they did not receive this information at the assessment stage of referral. External management must ensure that the statement of purpose is reviewed to reflect the format as per the national standards.

The model of care was described as an integrated relationship-based approach to care and its aim was to provide a framework for positive interventions with young people. It was underpinned by a behaviour management model, response ability pathways (RAP) and the circle of courage model including the three pillars. While staff at interview and on their questionnaires had an awareness of how the model was applied in practice, further evidence was required on centre records of how the care framework guides the team's day-to-day work with young people. Training was scheduled for staff in the new year. Inspectors saw some evidence on centre records of the model in use specifically regarding the centre's focus on the building of relationships with young people. This was supported with therapeutic input from the service's clinicians.

Standard 5.4 - The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

From a review by inspectors of centre files, there was evidence to show that there was a focus on care provision and safety for each young person in placement. However, improvements were necessary in how the review of care practices informed care practice so as to achieve better outcomes for the young people placed there. While the centre manager monitored the quality of care through their review of records, daily contact with the young people and communication with families and social workers, audits conducted by external management were irregular. Further, there was no evidence that reports on their findings were being implemented in the centre.

A review based on the themes as per the National Standards for Children's Residential Centres, 2018 (HIQA) had taken place at the beginning of 2020, but no action plan had been developed from this audit. As stated above, inspectors saw evidence of an improved quality assurance implementation plan for the centre including an outline of a timescale for completion of the process in 2021. This was to be conducted by a dedicated external monitor alongside the director of services.

There were centre registers in place for complaints, incidents and child protection concerns but improvements were required with regard to the recording, monitoring and analysing of these events. Complaints and concerns were discussed at team meetings and at one senior management meetings. Discussions in this regard were not observed on supervision records. Some significant event notifications (SENs) were individually discussed at team meetings, however a review of significant events as part of the significant event review group was not taking place consistently. When they were occurring, inspectors did not see evidence that they were being analysed to identify trends and inform learning opportunities for the staff team in a timely way.

The director of service told inspectors that a review of compliance was conducted for the centre.

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

Actions required

- The director of service must ensure that the centre's policies and procedures are revised to be in line with relevant legislation, national policy and national standards as soon as possible.
- The director of service must ensure that the implementation strategy for the new governance arrangements are completed without delay. Sole responsibility for the development and review of the centre's policies and procedures should not rest with one person only.
- Senior and centre management must ensure that staff receive training on the centre's revised policies and procedures. Any gaps in knowledge regarding child safeguarding reporting procedures, complaints and the national standards should be refreshed.
- Centre management must ensure that records are maintained of all internal management meetings and that there is evidence across centre records of their authority and decision-making.
- Centre management must keep a written record for the delegation of management tasks and key decisions made.
- The director of service must review the centre's risk management framework and strengthen existing risk identification, assessment and management systems.
- The director of service must ensure that the statement of purpose is available to young people and social workers.
- External management must ensure that the statement of purpose is reviewed to reflect the format as per the national standards.
- The centre manager must ensure that the model of care is used to guide the team's day-to-day work with young people.
- The director of service must ensure that regular audits are being conducted against the National Standards for Children's Residential Centres, 2018 (HIQA) and that they inform service improvement plans.
- The director of service must ensure that the system for tracking of complaints and concerns is reviewed. The significant event review group must meet regularly to monitor and analyse incidents and learning is communicated to the staff team in a timely way.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The director of service must ensure that the centre's policies and procedures are revised to be in line with relevant legislation, national policy and national standards as soon as possible. The director of service must ensure that the implementation strategy for the new governance arrangements are completed without delay. Sole responsibility for the development and review of the centre's policies and procedures should not rest with one person only.	The director of service will ensure that the centre's policies and procedures are revised so that they are in line with relevant legislation, national policy and national standards. Commencing in January 2021. The director of services will ensure that the implementation strategy for the new governance arrangements will be completed as per schedule provided to inspectors. Responsibility for the centre's policies and procedures will be shared by the manager, quality assurance coordinator and director of services. Commencing January 2021. .	Policies and procedures will be reviewed annually, or sooner where required by the centre manager and quality assurance co-ordinator. These policies will then be approved by the director of services. The quality assurance co-ordinator will review management and governance structures in the centre as part of bimonthly audits. The development and review of centre policies will also be included and feedback/recommendations will be provided to the centre manager and director of services through audit reports. Completed actions will be reviewed and signed off by the centre manager and quality assurance co-ordinator.

	Senior and centre management must ensure that staff receive training on the centre's revised policies and procedures. Any gaps in knowledge regarding child safeguarding reporting procedures, complaints and the national standards should be refreshed.	The centre manager will ensure that all policies & procedures are regularly revised at team meetings. The centre manager will ensure that the complaints policy, child safeguarding policy and national standards for young people's residential centres are reviewed quarterly in team meetings and as part of professional supervision with staff. Gateway Organisation will develop organisational Child Safeguarding training in line with Tulsa's Best Practice principles for Organisations in developing Children First Training Programmes. – To be completed by March 2021.	The team's understanding of centre policies and relevant national policies will be reviewed by the quality assurance co-ordinator as part of the centre's bimonthly audits, feedback/recommendations will be provided to the centre manager, the team and the director of services through audit reports. Completed actions will be reviewed and signed off by the centre manager and quality assurance co-ordinator.
	Centre management must ensure that records are maintained of all internal management meetings and that there is evidence across centre records of their authority and decision-making.	The centre manager has scheduled monthly management meetings for 2021 & will ensure that all records are maintained of these meetings and that these records evidence discussion, decisions made and have an action plan outlined. The centre manager will also ensure that evidence of feedback to the team regarding decision-making is recorded on centre records. Commenced December 2020.	The quality assurance co-ordinator will review records of internal management meetings and centre records as part of the centre's bimonthly audits. Feedback/recommendations will be provided to the centre manager, team and director of services through audit reports. Completed actions will be reviewed and signed off by the centre manager and quality assurance co-ordinator.

	Centre management must keep a written record for the delegation of management tasks and key decisions made.	The centre manager has developed a delegation log for the delegation of tasks to deputy management. The centre manager will add a column to reflect key decisions made. – Commenced in Dec 2020.	This will be reviewed by the quality assurance co-ordinator as part of the bimonthly audits. The director of services will also review this as part of their visit to the centre.
	The director of service must review the centre's risk management framework and strengthen existing risk identification, assessment and management systems.	The director of services will ensure that the centre's risk management framework is reviewed and that all staff are trained in the implementation of this framework, including risk identification, assessment, and management systems. Commenced Dec 2020 and will be completed March 2021.	Risk management will be added as a standing item on management meeting's agenda, this will be reviewed monthly as part of these meetings. The centre manager will provide feedback from these to the team. The quality assurance co-ordinator will review the centre's risk management systems as part of bi-monthly centre audits and provide feedback/recommendations, where required. Risk management training will be refreshed annually.
	The director of service must ensure that the statement of purpose is available to young people and social workers.	The statement of purpose and function is available to young people and their social workers. The young person's handbook, which is a child friendly version of the statement of purpose and function, is made available to young people during their transition to the centre/upon	The centre manager will ensure this occurs consistently when young people are admitted to the centre. This will also be reviewed as part of the centre's bimonthly audit.

		admission depending on the timeline.	
	External management must ensure that the statement of purpose is reviewed to reflect the format as per the national standards.	The statement of purpose has been reviewed to reflect the format as per the national standards.	The statement of purpose and function will be reviewed annually, or sooner if required, by the centre manager and director of services. This will also be reviewed by the quality assurance co-ordinator as part of the centre's bimonthly audit.
	The centre manager must ensure that the model of care is used to guide the team's day-to-day work with young people.	The centre manager will ensure that the model of care is used to guide the team's day-to-day work with young people, through observation of the team's approach with the young people and through regular review of the team's approach during supervision and team meetings. A refresher on the approach to care is scheduled for February 2021.	The team's implementation of the model of care will be reviewed as part of the centre's bimonthly audits through consultation with the team and young people. Any recommendations/feedback will be provided to the centre manager, team and director of services through audit reports and completed actions will be signed off by the centre manager and quality assurance co-ordinator.
	The director of service must ensure that regular audits are being conducted against the National Standards for Children's Residential Centres, 2018	The director of services has appointed a quality assurance coordinator to ensure that audits are being conducted against the National Standards for Children's	The director of services will have oversight of the centre's bimonthly audits through the provision of bi-monthly reports by the quality assurance co-ordinator. These will

	(HIQA) and that they inform service improvement plans. The director of service must ensure that the system for tracking of complaints and concerns is reviewed. The significant event review group must meet regularly to monitor and analyse incidents and learning is communicated to the staff team in a timely way.	Residential Centres, 2018 (HIQA) and that they inform service improvement plans. These audits will be completed bimonthly. Commencing January 2021. Complaints will be reviewed as a standing item on the management meeting and team meeting agenda and any learning outcomes from these will be discussed with the team. A register of complaints will be maintained in the centre. This will be monitored by the centre manager. The significant event review group will meet bi-monthly to monitor and analyse incidents, the centre manager will ensure that learning outcomes are communicated to the staff team in a timely manner. – Commencing January 2021.	include information reviewed, findings, recommendations and actions required in the centre. The director of services will review the centre complaints register quarterly as part of their centre visit. The quality assurance co-ordinator will review complaints, significant event notifications and minutes of all meetings in relation to the review and learning outcomes of these through the centre's bimonthly audits. Feedback/recommendations will be provided to the centre manager/team and director of services through centre audit reports. The centre manager and quality assurance co-ordinator will sign off on completed actions.