An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Registration and Inspection Service

Children's Residential Centre

Centre ID number: 005

Year: 2018

Lead inspector: Lorna Wogan

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Registration and Inspection Report

Inspection Year:	**2018**
Name of Organisation:	**Keys Childcare Ireland Keys Group**
Registered Capacity:	**Three young people**
Dates of Inspection:	**17th and 18th of January 2018**
Registration Status:	**Registered from the 29th of July 2015 to the 29th of July 2018**
Inspection Team:	**Lorna Wogan Noreen Bourke**
Date Report Issued:	**15th May 2018**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

The centre's purpose and function was to accommodate three young people of both genders from age thirteen to seventeen years on admission. At the time of the inspection there were three young people in placement.

The centre was registered to provide mainstream community-based residential care and aimed to provide a 'home-like' environment that supported the young people to integrate into the local community through education and extra-curricular activities. The manager indicated that the young people referred must have the ability to live within a multi-occupancy environment. The manager stated that the team were experienced in working with young people who have learning disabilities and they mainly implemented a behavioural approach in their work with young people. The staff team aimed to provide the young people access to positive role models, opportunities to learn and develop skills and to build a sense of attachment and belonging.

The centre was granted their first registration in July 2006 and was last inspected in April 2017. The inspection found there were considerable deficits in the overall governance and management of the centre and in the overall application of a clear model of care. Following this inspection the registration and inspection service met with the service director. They were satisfied, at that time that the corrective and preventative strategies identified by the provider, if fully implemented, were satisfactory to ensure the identified issues would not arise again.

This inspection report sets out the findings of an inspection carried out to review the implementation of the CAPA and to monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was in year three of the current registration cycle. The centre was registered without conditions from 29th of July 2015 to the 29th July 2018.

This inspection examined 'standard 1 purpose and function', 'standard 2 management and staffing', 'standard 4children's rights', 'standard 8 education' and 'standard 9 health' of the National Standards For Children's Residential Centres (2001). The inspectors also reviewed the status of the CAPA based action plan following the previous inspection. The inspection was unannounced and took place on the 17th and 18th of January 2018.

Based on the initial findings of this inspection the inspectors found there was substantial non-compliance in relation to the management, governance and oversight of the centre and a failure to show compliance with the Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III Article 5 Care and Operational Practices. The inspectors also found that the agreed CAPA and action plan submitted following the April 2017 inspection was not fully implemented as agreed following the meeting with the inspection service.

1.2 Methodology

This report is based on a range of inspection techniques including:

- An examination of the questionnaires completed by:

a) The regional service director

b) Two of the three social workers with responsibility for young people residing in the centre.

c) Two of the three young people residing in the centre

d) ACTs speech and language manager and social care worker

e) Two Guardian *ad litems* appointed to two young people residing in the centre

- An examination of the following relevant policies, centre files and recording process.

- Written statement of purpose and function and relevant policies
- Relevant sections of the care files
- Supervision records including centre managers supervision records
- Weekly data returns to provider
- Staff training records
- Record of management meetings since last inspection
- Record of in-house management meetings
- Record of team meetings
- House meeting records
- Handover records
- Register of significant events
- Complaint register

- Interviews with relevant persons that were deemed by the inspection team as to having a bona fide interest in the operation of the centre including but not exclusively

a) The centre manager
b) The deputy manager

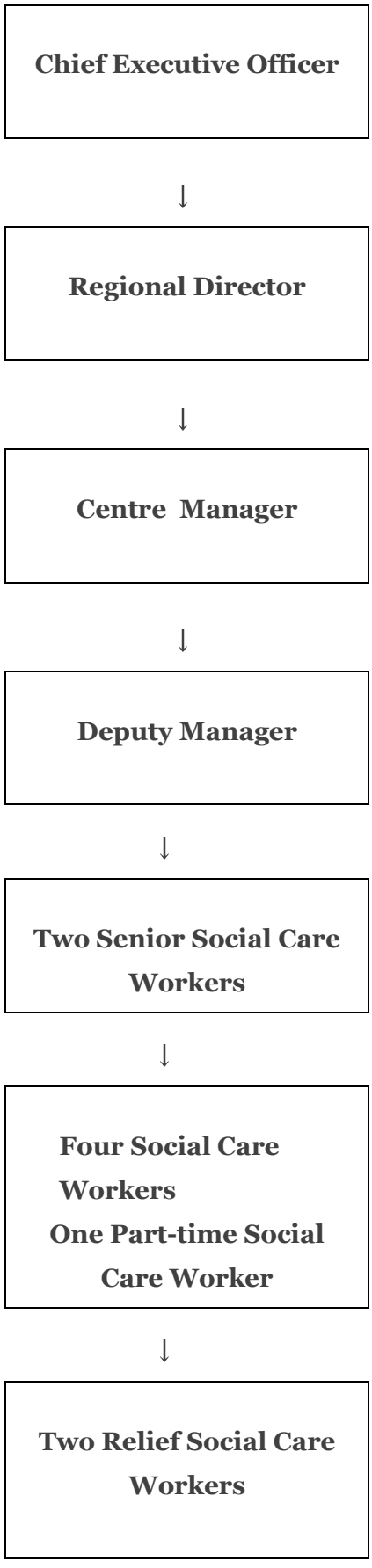
c) Two senior social care workers
d) Five social care workers
e) Two relief social care workers
f) The director of quality and regulation
g) Two of the young people
h) Three social workers
i) One aftercare worker
j) ACTS speech and language manager and social care worker

- Observations of care practice routines and the staff/young people's interactions.

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.

1.2 Organisational Structure



2. Findings with regard to registration matters

In the course of this inspection the inspectors found that there were substantial non-compliance and deficits in the overall governance and management of the centre and failure to show compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. The registrar and the regional manager of the registration and inspection service met with the service director following the inspection. A condition was placed on the centre refraining them from accepting any new admissions until such a time as the inspection process was complete and the service could demonstrate that management governance and oversight of the centre was more effective and the appropriate care and operational practices were in place having regard for the children residing in the centre and the nature of their needs.

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 27th February 2018. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The director of services returned the report with a satisfactory completed action plan (CAPA) on the 26th March 2018 and the inspection service received evidence of the issues addressed and that all outstanding regulatory matters had been addressed, thus the condition placed on the service refraining them from accepting new admissions was removed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to now be operating in adherence to the regulatory frameworks and Standards in line with its registration. As such it is the decision of the Child and Family Agency to continue to register this centre, ID Number: 005 without attached conditions pursuant to Part VIII, 1991 Child Care Act.

The period of registration being from the 29th of July 2015 to the 29th of July 2018.

3. Analysis of Findings

3.1 Purpose and Function

Standard

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

3.1.1 Practices that met the required standard in full

None identified.

3.1.2 Practices that met the required standard in some respect only

The centre manager informed the inspectors they had reviewed the written statement of purpose and function in conjunction with the regional service director. The updated written statement was made available to the inspectors. The document evidenced that a review was undertaken in January 2018.

The inspectors found that the written statement of purpose and function was not adequately reviewed in line with the required actions identified following the previous inspection in April 2017. The written statement of purpose and function had not been subject to any substantial review by the staff team, the manager and the regional director as outlined in the written statement. The statement of purpose and function made reference to the former State agency responsible for children's services with no reference to new State agency for children's services, TUSLA, which was established on 1st January 2014. The statement did not reflect the recent changes within the parent company nor did it accurately reflect their current provision of residential services here in Ireland.

There was no evidence that the senior management team allocated time to specifically agree a model of care that would underpin the care provided to the young people. The provider had not implemented the 'Safe and Sound' model of care that operated in the providers other care homes as outlined in the CAPA based action plan. The inspectors found that the written statement of purpose had not reflected the care approach required to meet the needs of the young people. This impacted on the centre's ability to define the population of young people the centre catered for.

The statement indicated that the parent company employed a team of therapists and planned to expand this to include an identified therapist for this home. There was no

therapist identified for the home for a significant length of time and the inspectors found that there was no clinical oversight of the provision of care in respect of the young people's emotional and psychological care. This deficit was also reflected in the day-to-day operation of the centre in areas such as placement planning.

Staff interviewed by the inspectors struggled to define the model of care and most staff indicated that they implement the principles of Therapeutic Crisis Intervention when engaging the young people particularly when they present with challenging behaviour. The inspectors found that staff were unable to define theories that informed their work or researched based approaches to working with young people in residential care. The team relied on external professionals currently engaged with young people to assist them to respond to the young people's needs.

The statement was not available in a form that was accessible to young people, families, supervising social workers and any other persons with a legitimate interest in the work of the centre. The written statement did not identify the names of those who undertook the review of the written statement of purpose and function nor did it evidence the annual review timescale as required under the National Standards for Children's Residential Centres 2001.

Required Action

- The service director and the centre manager must develop a statement that clearly defines the purpose and function of the centre, the population it caters for and the service it aims to provide, with specific reference to the centres model of care and is kept up to date with responsibility for this clearly identified.

- The service director and the centre manager must ensure the statement available in a form that is accessible to young people, families, social workers and any other persons with a legitimate interest in the work of the centre.

- The service director and the centre manager must ensure that staff members are consulted and involved in the review of the centres statement of purpose and function to ensure they are familiar with the content of the statement, understand it and are confident that the statement is reflected in care practice.

3.1.3 Practices that did not meet the required standard

None identified.

3.2 Management and Staffing

Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

3.2.1 Practices that met the required standard in full

None identified.

3.2.2 Practices that met the required standard in some respect only

Register

The centre manager maintained a register of all children who lived in the centre to date. The centre register of admissions and discharges was accurate and up-to-date however parents' addresses were not consistently recorded on the centre register and the gender of the residents was not identified as required under the regulations.

The centre register recorded details in relation to the most recent admission and discharge from the centre since the last inspection. There was one unplanned discharge from the centre in June 2017 and one new admission in August 2017. As previously stated this placement was outside the registered age-range for the centre and derogation was granted to permit the placement to be made.

There was a system in place where duplicated records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

Notification of Significant Events

Notifications were made to the relevant parties that included the social workers, lead inspector, director of service, Guardian *ad litems* and the national significant event notification team. The social workers were satisfied the centre had a prompt notification procedure in place. The centre manager stated that social workers responded to notifications and sought further clarification if required. The centre maintained a written log of all significant event notifications from the centre.

The centre records evidenced a decrease in incidents for one young person in the past six months and the young person's social worker stated this was a good indicator of

the progress the young person was making and there was evidence that staff were following the behaviour management plan. In general, significant events arising in the centre related to incidents of behaviour that challenged, self harm and health and safety concerns.

The centre manager completed weekly returns to the director of service that included data in relation to significant events that occurred in the previous week. However, as agreed in the CAPA based action plan a system for the review of significant events on a six week basis by external managers had not taken place since the last inspection. The inspectors found no evidence of feedback from the external manager following receipt of significant events relating to the young people. Staff interviewed informed the inspectors that there were no structured systems in place to look back on significant events to identify learning outcomes for the team.

The lead inspector responsible for the oversight of significant events found that written reports did not always evidence a planned therapeutic approach to managing behaviours that challenged. The lead inspector also found that the manager's oversight of significant events did not evidence a sufficient analysis of incidents to facilitate a learning approach within the team. The findings of the inspectors were that staff were not provided with sufficient feedback in relation to the managers overview and assessment of the incidents.

There was evidence that risk assessments were updated as required following significant events. However, following a recent incident the inspectors found that all potential risks had not been adequately addressed in the written risk assessment. The centre manager must develop and review risk assessments in consultation with the team to ensure they are satisfied it adequately addresses all potential and known concerns and risks and is signed off by the service director and forwarded to the relevant social workers.

Staffing

The staff team were experienced and appropriately qualified. There was a good skills mix of experienced and qualified staff on the team. Two new relief care staff had been recruited to work in the centre since the last inspection. The inspectors examined their personnel files and found that the relief staff were appropriately qualified to work at the centre and the required vetting documentation was secured prior to their employment. The centre had not employed agency staff since the last inspection. The inspectors reviewed the staff rosters and found that a consistent team was in place.

The inspectors found there were adequate numbers of staff in place to care for the young people however the inspectors found the staff resources were not sufficient to facilitate and ensure team meetings, staff supervision, in-house management meetings, key-work meetings and other administrative functions were undertaken. The inspectors found that the core and relief staff resources were fully utilised to provide the required level of supervision of the young people and this resulted in staff not having the staffing resources for all the required ancillary duties. Inspectors found that the relief staff and senior staff were providing additional cover over day shifts therefore were not as available to cover sick leave and annual leave as it arose.

The inspectors found that the staff acted as positive role models to the young people. Two of the young people told the inspector that they had good relationships with the staff team and that their lives had improved since admission. The most recently placed young person was in the early stages of establishing their relationship with staff working in the centre. Social workers told the inspector that the staff team were committed and supportive of the young people in placement.

Inspectors found that the current system of staff induction was inadequate and did not reflect the written centre policy on staff induction. New staff members received a staff induction booklet however the inspectors were not satisfied that the information contained in the induction booklet was sufficient in itself. There was no evidence on the personnel files that staff had participated in a formal and structured induction process.

Supervision and support

The inspectors examined ten supervision files including the centre manager's supervision records. The inspectors found that formal structured staff supervision was not undertaken in accordance with the centre policy. Staff supervision was not structured, robust, regular or consistent. There was no supervision schedule established at the centre. The inspectors found that training for staff in the company's supervision model as agreed in the previous inspection action plan had not been provided for supervisors and supervisees. There was evidence that supervision of senior social care staff was generally an informal and opportunistic meeting with their supervisor. Supervision records maintained by the manager were not consistently signed by the supervisees and the supervision records maintained by the centre manager were not of an appropriate standard.

Inspectors found that a number of staff did not invest in the supervision process and some staff indicated that there had been breaches in confidentiality around staff supervision therefore they had lost confidence in the process. Supervision records did not evidence discussions around the implementation of individual placement plans in accordance with the national standards. Supervisors informed the inspectors they found it difficult to set aside time to provide formal supervision due to the demands to provide adequate supervision of the young people.

The inspectors found evidence of good peer support and staff mentoring within the team. Staff interviewed stated that they received good support from the deputy manager and the senior social care staff. However, the inspectors found that staff morale was generally low within the team. A number of staff informed the inspectors that they oftentimes felt undermined and undervalued in their work. Staff presented as frustrated that many of the actions agreed following the last inspection had not been acted upon and the few improvements that were initiated had not been sustained.

The inspectors found there was no evidence of oversight of supervision records by centre manager or external service director.

The centre had a written policy on debriefing staff however the inspectors found it was inadequate and lacked sufficient detail in relation to outlining the support mechanisms in place for staff. The inspectors found that there was no structured debriefing procedure or post crisis response following critical incidents at the centre. The centre manager and staff were unsure if the organisation had a policy in relation to support mechanisms for staff, in particular for those who have suffered stress or injury in their course of their work and the written policy document reviewed by the inspectors did not evidence such a policy.

The inspectors found that team meetings had not taken place in accordance with the centre policy and in most cases the attendees consisted of the staff members going off duty and staff coming on duty. Dates of team meetings were not scheduled in advance and many staff interviewed were not invested in the current team meeting process.

Handover meetings took place each day however there was evidence that the centre manager was not always present for the handover meeting. The findings of the inspectors were that the decision-making process in relation to the day-to-day plans and care of the young people did not allow for a consistent approach to their work. The inspectors found that decisions made by the team at handover meetings were at

times subsequently overturned by the internal manager. There was no documented evidence of the reasons why decisions taken were overturned by management.

Out of hours on-call support was provided on a rotational basis by the centre manager, the deputy manager and the two senior social care staff members.

Training and development

The inspectors found that a workforce development plan had not been prepared by senior management as outlined in the CAPA based action plan. The inspectors found that staff were provided with core training in child protection, TCI, first aid and fire training however there was no additional training for staff to support them to work with complex young people and to assist them to further develop their knowledge base and the skills required to work with young people with complex presentations. Apart from core training the team had not received any additional training since the last inspection to assist them to develop their therapeutic approach based on the defined needs of the young people.

The centre manager maintained a record of all training undertaken by the staff team. Inspectors found there were four staff members who had not completed child protection training, two staff members required refresher first aid training and six staff members required the annual fire safety training. The centre manager must ensure that the staff are facilitated to complete core training.

Administrative files

The inspectors examined a range of administrative files and records including daily logs, visitors log, significant event log, complaints register, supervision records, handover records and minutes of staff meetings and house meetings. The care files and centre records were generally well organised and maintained to facilitate effective management and accountability.

There was no evidence that the centre manager had systems in place to monitor the care files and the centre administrative records. The centre manager must ensure there are systems in place to monitor the quality of all centre records and evidence any action taken to remedy deficiencies to safeguard the interests of residents and staff.

Through staff interviews the inspectors found that the centre manager and staff were not familiar with the requirements of the Freedom of Information Act, 1997 and 2003. The inspectors also found that staff had limited understanding of data protection legislation and the implementation of sound data protection practices at the centre.

There were financial management systems in place in the centre which involved the use of petty cash and receipts. Petty cash records evidenced the day-to-day expenditure at the centre. Petty cash was available to support the staff team in their work with the young people such as doing activities together.

3.2.3 Practices that did not meet the required standard

Management

The centre manager was appropriately qualified and had the required experience to undertake the role of centre manager. There was a management structure in place however the inspectors found deficits in the governance and management systems in place.

The written statement of purpose and function stated that the operational manager would visit the centre at least every month to provide support, supervision and management of the service. The inspectors found that visits to the centre by the regional director had not been undertaken in a consistent manner and the inspectors found they had visited the centre on two occasions only since the last inspection in April 2017.

As outlined in standard 3.1 the inspectors found that the current external management systems were not fit for purpose in terms of ensuring accountability, quality assuring practices and supporting the staff team in their work. Governance and management systems to address previously identified deficits were not in place. The centre manager informed inspectors they had face-to-face contact with the service director once every two to three months approximately however there were no records to evidence all of these contacts.

The inspectors found that the team had insufficient leadership from management. There was evidence throughout staff interviews that they felt isolated from the parent company in the overall operation of the centre. Staff stated they were informed they could contact the external manager at any time however they confirmed they did not

have regular and consistent access to them. Inspectors found that staff had not been provided with sufficient guidance, support or feedback from the external manager in relation to their work with the young people at the centre. Staff interviewed confirmed that following the last inspection they were provided with an opportunity to meet individually external service director. The inspectors found that a number of staff members that availed of this opportunity felt they had not received a satisfactory response to the issues raised with the director.

The inspectors found deficits in the internal governance and management of the centre. As highlighted in the previous inspection there was evidence that the centre manager was not available or accessible to staff or young people on a regular and consistent basis. The centre manager was rostered to work four days each week however at the time of the inspection they were also attending college and this further impacted their time at the centre. The rosters reviewed over a four month period showed that the manager was present at the centre on average three days a week. Inspectors found the staff roster did not consistently evidence who was covering the managers role on days the manager was absent from the centre. The inspectors found that senior staff when on duty undertook management responsibility on their own initiative to ensure the basic management tasks were completed when the centre manager was absent from the centre.

The inspectors found gaps in the oversight of some care practices and operational policies. There was no evidence to indicate that key policies, procedures and care approaches had been reviewed and updated to ensure they were up-to-date, reflected an agreed model of care and were suitable to the care of a younger child. Some key policies reviewed by inspectors were not adapted to ensure they were suitable and relevant within this jurisdiction.

Inspectors reviewed the records of in-house management meetings. These records confirmed that there were five in-house management meetings between June and September 2017 however, no further meetings had been scheduled since that date. The records show that the service director attended one of these meetings in June 2017. The senior staff members interviewed stated that these meetings were beneficial and productive forums to ensure good communication and planning around the management of the centre. The inspectors found that there was no established forum for senior managers and care staff to evaluate their work or contribute to issues that require effective change within the centre. The service director indicated in their inspection questionnaire that they undertook monitoring

visits to the centre however the inspectors found no evidence on the centre records of these visits or any evidence of the outcome of these visits.

3.2.4 Regulation Based Requirements

The Child and Family Agency has met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV, Article 21, Register.***

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 6, Paragraph 2, Change of Person in Charge
-Part III, Article 16, Notification of Significant Events.
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)

The centre has not met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 5, Care Practices and Operational Policies

Required Action

- The director of services must ensure there are appropriate external management and monitoring arrangements in place to ensure the centre is effectively managed and staff are organised to deliver the best possible care and protection for young people in placement.
- The director of services must develop an effective ongoing staff development and training programme for the care and education of staff.
- The director of service must have in place mechanisms for assessing the quality and effectiveness of the services provided by the centre, particularly outcomes for the young people.
- The centre manager must ensure the register of all young people who live in the centre is maintained in compliance with the regulatory requirements.
- The service director in conjunction with the centre manager must develop a formal and structured induction process and staff induction must be evidenced on the personnel files and within the supervision process.
- The service director must ensure that the roster arrangements reflect the need for staff to attend team meetings, in-house management meetings, undertake individual key-work, attend training and complete administrative tasks as required.

- The service director must provide training for staff in supervision practice and have systems in place to monitor the quality and effectiveness of supervision at the centre.
- The service director must ensure they meet with the team regularly and provide opportunities for staff to contribute to the overall development of the centre and be involved in decision making processes within the centre. The director must also provide opportunities for staff to meet with the director individually.

3.4 Children's Rights

Standard

The rights of the Young People are reflected in all centre policies and care practices. Young People and their parents are informed of their rights by supervising social workers and centre staff.

3.4.1 Practices that met the required standard in full

Consultation

The inspector found that the views of the young people were sought by social workers and key-workers when decisions were being made that affect their daily life and future. The records showed that young people were consulted about the day-to-day running of the centre. House meetings provided the young people with the opportunity to get involved in the running of the centre and they could raise issues that were important to them. The inspector found that the young people were appropriately involved in the daily routines of the centre and could exercise choice across a range of daily living skills for example buying clothes, use of pocket money, food menus or furnishing of the home.

The young people were encouraged to participate in decision making about their lives. They were consulted and encouraged to participate in planning for their placement and in statutory care plan reviews. The young people completed consultation forms prior to their statutory review meetings and staff supported and encouraged the young people to participate in their care plan meetings. The young people interviewed stated they were given the opportunity to ask questions and express their views at care planning meetings. There was evidence that the staff team were strong advocates for the young people and this was confirmed by the social workers interviewed by inspectors.

Access to information

The centre had a written policy on young people's access to information. The young people were aware of their right to access their records and information recorded about them. There was evidence that the young people had access to their key-work records which they signed when read. Access to the daily logs and care files by the young people had to be planned with their key-worker and the centre manager. Social workers interviewed stated that they provided the young people with access to

information about themselves and the reasons why they were in care in accordance with their age and level of understanding.

The young people had access to information on the national advocacy service Empowering People in Care (EPIC) and had engaged with area advocates on a number of occasions at the centre.

3.4.2 Practices that met the required standard in some respect only

None identified.

3.4.3 Practices that did not meet the required standard

Complaints

The centre had a written complaints procedure. Inspectors found this policy was not up to date and the centre had not adhered to its own policy in relation to the management of complaints. The policy required a clear definition of a complaint and must set out clear and reasonable time limits for action in relation to handling complaints.

The young people interviewed were aware of their right to make a complaint about any aspect of their care. The centre maintained a complaints logbook. However, significant deficits were identified by inspectors in the management of young people's complaints.

The inspectors found there were no complaints recorded since the last inspection. On reviewing the complaints logbook inspectors found that the centres own complaints procedure was not followed. The outcome of the complaints was not recorded, the date complaints were responded to were not identified, there was no record that young people received feedback following the investigation of their complaint and no record to indicate whether the young people were satisfied or not with the outcome of their complaint.

Throughout the inspection process inspectors became aware of issues of dissatisfaction raised by the young people relating to aspects of their care and these were not dealt with as complaints and were not recorded as such on the complaints log. Staff confirmed in interview with the inspectors that only serious and/or formal complaints were recorded on the centres complaints logbook on the register and this generally required the young people to write down their complaint on the centres

complaints pro forma. There was evidence that staff empowered young people to raise their issues of concern however the inspectors found evidence that these matters of concern were not always appropriately dealt with and followed through to a final conclusion by the management team. Children's complaints were not reviewed at team meetings to monitor the status of the complaints investigation or to identify learning outcomes following the complaint. The inspectors advise that the centre complaints procedure must be user-friendly, non-adversarial and positive in its response.

The staff were not provided with training to fully implement the centres complaints procedure as outlined in the CAPA based action plan. The centre manager was unsure if the young people were provided with an age appropriate copy of the complaints procedures. The centre manager confirmed that staff were not provided with a copy of the complaints procedure as agreed following the last inspection.

3.4.4 Regulation Based Requirements

The Child and Family Agency has met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995, Part II, Article 4, Consultation with Young People.***

Required Action

- The service director and the centre manager must review and update the centre's complaints procedure and put systems in place to monitor the implementation of the complaints procedure at the centre.
- The centre manager must ensure that young people are fully supported and facilitated to make a complaint.

3.8 Education

Standard

All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate educational facilities.

3.8.1 Practices that met the required standard in full

The inspector found that young people's right to education was promoted by the staff team and education was valued within the centre. The supervising social workers and the centre staff ensured each of the young people had access to appropriate educational facilities. The young people were educated with their peers within the community. Two of the young people attended mainstream education and inspectors found that they were well integrated into their school community and had good attendance records. One young person was on a reduced timetable in their allocated school placement and there was evidence that the staff provided every possible support to the school to maintain the allocated hours within the school environment. Staff also assisted and supported this young person to undertake an educative training course on-line.

There was evidence that deficits in educational attainment were actively addressed through the provision of tuition or additional assistance with homework. One of the young people was attending afterschool study four days per week and there was evidence that this was beneficial to them. There was evidence of good co-operation and communication between the school, the social workers and the centre staff. There were good routines in relation to completing homework on a daily basis and staff provided appropriate support to the young people in relation to their schoolwork. There were appropriate physical facilities to support the young people with their studies.

There was evidence of school progress reports on file and of staff attendance at parent teacher meetings. The young people's educational progress was subject to review at the statutory care plan meetings.

The inspectors found some deficits on the care files in relation to the young people's educational histories. The centre manager must ensure that social workers secure this information during the admission process.

3.8.2 Practices that met the required standard in some respect only

None identified.

3.8.3 Practices that did not meet the required standard

None identified.

3.9 Health

Standard

The health needs of the young person are assessed and met. They are given information and support to make age appropriate choices in relation to their health.

3.9.1 Practices that met the required standard in full

None identified.

3.9.2 Practices that met the required standard in some respect only

Two of the three young people had access to a local general practitioner and staff were actively working to secure a local general practitioner for the most recent admission. The young people attended other ancillary health services such as dentists, opticians and other specialist services when required. The young people had a valid medical card in their own right.

There was evidence that the centre staff sought prompt medical attention for the young people and were alert to early signs and symptoms of illness. Social workers confirmed they were notified without delay of any significant problem relating to the young people's health. Records of medical contacts were maintained at the centre.

Past medical and health information and immunisation records relating to the young people in placement were not evident on the individual care files at the time of the inspection. The centre manager must ensure immunisation records along with a complete record of all past medical and health information is maintained on the individual care files. A note must be recorded on file where information is absent outlining the efforts made to obtain the information.

The centre had a medication administration policy and there were procedures in place for the administration and disposal of medications. The centre records contained a clear record of all medications administered both prescribed and non-prescribed medications. The inspectors advise that staff members complete certified training in the safe administration of medication.

Medications were stored in a secured box and individual medication storage boxes were maintained for each young person. The young people's name and prescribed medications were appropriately identified on the medication boxes.

There was evidence that the staff encouraged the young people to participate in activity based programmes and develop healthy lifestyles such as going to the gym and taking regular walks. Staff also provided appropriate health education key work sessions in areas such as smoking, diet and exercise, physical/sexual development and alcohol/substance misuse however this work was not always reflected in the key-work records.

A sufficient number of staff were trained in first aid and this training was up to date for these staff members. A first aid kit was available in the centre and staff were competent to administer first aid. The inspectors found the first aid kit was not fully stocked and there was no system in place to ensure that adequate supplies were maintained in the first aid kit.

The centre had a policy on smoking in place that safeguarded the health of the young people and staff. One of the young people smoked and staff had a clear policy that they did not purchase cigarettes for the young person. It was centre policy that staff who did smoke were not permitted to smoke in front of the young people. The staff periodically reminded the young people of the health risks associated with smoking. There was a designated smoking area away from the house to facilitate staff who smoked.

There was evidence that the young people were offered a nutritious and varied diet which involved an element of choice.

The inspectors could not locate written medical consent on the care files. The social workers must secure where possible written parental consent regarding medical care in respect of their child.

3.9.3 Practices that did not meet the required standard

None identified.

3.9.4 Regulation Based Requirements

The Child and Family Agency has met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995, Part IV, Article 20, Medical Examinations.***

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 10, Health Care (Access to Specialist Health Care Services).***

Required Action

- The centre manager must ensure immunisation records along with a complete record of all past medical and health information is maintained on the individual care files. A note must be recorded on file where information is absent outlining the efforts made to obtain the information.
- The social workers must secure where possible written parental consent regarding medical care in respect of their child.
- The centre manager must have a system in place to ensure that adequate supplies are maintained in the first aid kit.

4. Action Plan

Standard	Issues Requiring Action	Response with time scales	Corrective and Preventative Strategies To Ensure Issues Do Not Arise Again
3.1	The service director and the centre manager must develop a statement that clearly defines the purpose and function of the centre, the population it caters for and the service it aims to provide, with specific reference to the centres model of care and is kept up to date with responsibility for this clearly identified.	The statement of purpose and function is being fully reviewed and is currently drafted with final version to be approved by 26th April 2018.	Annual review schedule established. Centre manager must review prior to end of March each calendar year and submit to centre director for approval by end April each calendar year. Changes to the centre's function throughout the year will instigate version amendments until annual review.
	The service director and the centre manager must ensure the statement available in a form that is accessible to young people, families, social workers and any other persons with a legitimate interest in the work of the centre.	Once the final statement of purpose and function is approved a summary version will be created to ensure accessibility with reference and full availability to the fuller version due end May 2018.	Summary versions will be created 1 month after the fuller version is approved each year in April 18.
	The service director and the centre manager must ensure that staff members are consulted and involved in the review of	Research underway by centre manager and service director into models of care. Staff team were invited to research and add voice	Following any review of the statement, all staff will be provided with a copy which they can retain for their own reference, plus a copy

	the centres statement of purpose and function to ensure they are familiar with the content of the statement, understand it and are confident that the statement is reflected in care practice.	to the process. Manager and staff will hold a forum on 9th April to discuss the process so far. This process is linked directly into the recruitment which is underway for a clinical psychologist to oversee and provide staff support. Consultation with staff has commenced in reviewing the statement, with a meeting held with the service director in February 18 to provide refresher information on the reason a centre has a purpose and function and everyone's responsibility to take ownership of learning under the direction of the centre manager. Once the final draft has been compiled staff will be invited to comment to contribute to further revision. From 12th April 2018.	made available at all times in the office. Staff will be tasked with reading and signing that they have received a copy and that they understand the content and the connection to their care practices. This with be a standard item on the staff meeting agenda to ensure that the document is a live working representation on the homes purpose and function.
3.2	The director of services must ensure there are appropriate external management and monitoring arrangements in place to ensure the centre is effectively managed and staff are organised to deliver the best possible care and protection for young people in placement.	The service director has scheduled monthly all day visits to the centre on the following dates. During these visits the director will review records, speak with children and staff, hold supervision with the centre manager. In addition independent internal auditing will be arranged for June 18, Sept 18, Dec 18 and March 2019.	All centre visits have been scheduled by the service director. Notes of the visit will be produced following each visit with actions agreed and followed up throughout the month.

		Weekly reports must be completed by the centre manager and returned to the service director. A quarterly quality review report has been devised to monitor and evaluate the quality of care and protection arrangements for the children residing in the home. The first report has been completed for quarter 1 and is with the service director for approval and comment by 01.04.18. This report contains the homes development plan. The outputs from the report are shared at the company governance committee and the senior leadership team meetings.	Quarterly independent internal audit arrangements have been made to commence. The quarterly quality review of care report must be submitted to the service director by end of each quarter.
	The director of services must develop an effective ongoing staff development and training programme for the care and education of staff.	Work is underway to establish to enhance the mandatory training schedule with essential and enhanced training opportunities for staff. Staff commenced the safe and sound workbook in February 2018. The progress of completion is checked monthly by the service director. All staff have completed the first module. Target set to complete all modules by 31.05.18.	Training programme to be reviewed as per each quarterly quality of care review report.
	The director of service must have in place mechanisms for assessing the quality and	The quarterly quality review of care has been implemented to assess, evaluate and monitor	The requirement that the service director will visit as a minimum monthly will review the

	effectiveness of the services provided by the centre, particularly outcomes for the young people.	the progress children are making towards their agreed outcomes. This review involves staff, children and stakeholders and will be discussed with staff on 19.04.18. The outputs of this review will be the development plan for the home which will be closely monitored by the service director. This is combined with monthly visits, supervision with centre manager, viewing all incidents and speaking with staff and children.	service in line with the centre's systems and speak with staff and children has been established as a standard.
	The centre manager must ensure the register of all young people who live in the centre is maintained in compliance with the regulatory requirements.	Complete 23.03.18.	The register will be checked by the service director as each visit.
	The service director in conjunction with the centre manager must develop a formal and structured induction process and staff induction should be evidenced on the personnel files and within the supervision process.	Induction programme to be reviewed in line with current company review of the induction programme which is time lined to be completed in June 18. A full audit of all staff files will be undertaken by May 2018 to ensure that the records for inductions are present. All staff who are being inducted to the centre and up until 6 months employment must be provided with supervision every fortnight.	The centre's staff will require to undertake the same induction process as for all of the company residential homes, with necessary adaptations made to meet differing legal and regulatory frameworks in different jurisdictions. The policy on induction will be reviewed and set the standard process for the centre.

	The service director must ensure that the roster arrangements reflect the need for staff to attend team meetings, in-house management meetings, undertake individual key-work, attend training and complete administrative tasks as required.	The roster template format has been reviewed to ensure that it fully describes the staffing arrangements within the centre. Complete.	A revised template will allow for the descriptions of the arrangements of staff to be included.
	The service director must provide training for staff in supervision practice and have systems in place to monitor the quality and effectiveness of supervision practice at the centre.	All staff have completed the first module of a training workbook in groups and in supervision which covers the topic of reflection. All supervision sessions must have an element that includes reflection. Staff in supervisory roles will receive formal training by end May 2018. Supervision records will be quality assured by the centre manager and the service director. Evidence of this quality assurance process will be visible in the records. External supervision for supervisees is being sourced by the company.	The revised training programme will require and evidence that all supervisory staff are required to attend training on supervision for supervisees. The service director will monitor and sample supervision records as part of the monthly visit.
	The service director must ensure they meet with the team regularly and provide opportunities for staff to contribute to the overall development of the centre and be consulted in decision- making processes within the centre. The director must also	The service director has met with the whole staff team on 22.02.18. Clear communication was provided at this meeting to all staff to invite anyone to meet with the service director. Contact telephone numbers were provided to all staff also.	The monthly visit dates are planned to coincide with planned staff meetings to enable positive relationships of support to form.

	provide opportunities for staff to meet with the director individually.	The service director has contacted the home after any incidents especially at the weekends and offered the opportunity for staff to discuss.	
3.4	The service director and the centre manager must review and update the centre's complaints procedure and put systems in place to monitor the implementation of the complaints procedure at the centre. The centre manager must ensure that young people are fully supported and facilitated to make a complaint.	All centre's policies had undergone the first draft review and are now with the service director for further review. All complaints must be copied to the service director who will monitor the application of the policy. All staff will be provided with the revised policies on 19.04.18. An information session will be held on the complaints procedure. By end April 18 the children will have received written and verbal information on making a complaint, in a key work session and in a residents meeting. The home will adopt a structured 'you said, we did' approach and demonstrate this within the home.	Centre policies to be reviewed in March each calendar year and forwarded for approval to the director for implementation in April of each calendar year. Complaint's training is a mandatory training which all staff require to attend. Any complaint must be forwarded to the service director. All children who are new to the home are required to receive information on how to complain. A key work session on making complaints will be mandatory. The service director will ask children about making complaints as part of the monitoring visit. The service director will ensure that the 'you

			said, we did' approach is adopted in the home, research has shown that this user friendly mechanisms is ideally placed to work in children's homes.
3.8	No required action		
3.9	The centre manager must ensure immunisation records along with a complete record of all past medical and health information is maintained on the individual care files**.** A note must be recorded on file where information is absent outlining the efforts made to obtain the information.	All immunisation records/medical and health records have been requested from each social worker and evidence of request in place.	Immunisation records as part of the admission process and must be gathered at this point.
	The social workers must secure where possible written parental consent regarding medical care in respect of their child.	Social workers have been requested to provide written parental consent and a record held if this request was unable to be fulfilled including the reason.	Parental consent will be requested from the social workers on admission as per admission procedure. A record of the request and outcome will be maintained. The quarterly independent audits which review individual care checking to ensure that all required records are in place.
	The centre manager must have a system in place to ensure that adequate supplies are maintained in the first aid kit.	Complete 23.03.18. All staff have now received first aid training.	A member of staff has been assigned as responsible for maintaining the first aid box supplies. The task for undertaking checks has

			been added to the daily centre planner.