An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 013

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Gateway Children's Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced Inspection**
Date of inspection:	**31st May, 01st & 02nd June 2023**
Registration Status:	**Registered from 25th September 2023 to 25th September 2026**
Inspection Team:	**Lorna Wogan** **Linda McGuinness**
Date Report Issued:	**22nd August 2023**

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 in 2007. At the time of this inspection the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from 25th of September 2020 to 25th of September 2023.

The centre was registered as a multi-occupancy unit to provide medium to long term residential care for four young people from age thirteen to seventeen years on admission. The centre aimed to help young people recover from adverse life experiences. The model of care was built on the three pillars of trauma informed care. The three pillars being safety, connections, and coping. The approach to working with young people was also informed by attachment and resilience theories. The staff team aimed to increase protective factors and promote resilience by providing a safe environment, access to positive role models, opportunities to learn and develop skills and to build a sense of attachment/belonging. There were four young people 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	1.6
4: Health, Wellbeing and Development	4.2
6: Responsive Workforce	6.3

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 6th July 2023. 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 18th July 2023. 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: 013 without attached conditions from the 25th September 2023 to the 25th September 2026 from the pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

The inspectors met with each of the four young people in placement. One of the young people interviewed was recently admitted to the centre. The young people told the inspectors that staff provided them with opportunities to have their views heard, decisions taken by staff were explained to them and overall, they described staff as 'fair.' One young person rated their satisfaction with the centre as 7/10. At the time of the inspection house meetings were not taking place with the full resident group due to group dynamics and young people were engaged individually to ascertain their views. The inspectors recommend this decision is reviewed as the group dynamics change and resolve in time. One young person told the inspectors that sometimes the house meetings felt like they were led by a staff agenda rather than a meeting led by the young people. The centre manager must consider how they can further develop the house meeting forum to enable and support the young people to become more invested in it. The records of recent house meetings were an amalgamation of the issues raised by the young people individually however the record read like all young people were present at the meeting together and this misrepresented the house meeting process. The records must accurately reflect the fact young people were engaged on their views on an individual basis. The inspectors found the records reviewed did not reflect the feedback provided to young people to issues raised by them and the team meeting records did not consistently reflect the decisions taken in response to issues raised by the young people.

Two of the longer-term residents spoke to the inspectors about the impact of staff leaving over the past year and the challenges adjusting to new staff members. A number of key staff and long-standing members of the team had moved on over the past 12 months. The inspectors recommend that the impact of staff changes is acknowledged individually with young people in key working. However, there was

evidence of some key staff returning to the centre to mark significant events with the young people which the young people appreciated.
One young person raised issues they had with their social worker and expressed their view that there was a lack of consultation with them in relation to their placement which was a considerable distance from their community of origin. This impacted on the frequency of visits with their parent who was involved in their life. The social worker informed the inspectors the young person was previously in a special emergency arrangement and this was the only residential placement available to them. They social worker acknowledged the young person's anxieties and concerns in relation to the distance of the centre from their parent. At the time of the inspection the inspectors were satisfied that family contact arrangements were scheduled for the initial three months of placement but the distance from their home community would be a challenge for all, however family contact will be critically important in the context of sustaining the placement.

The inspectors found that complaints made by young people of feeling unsafe in the centre were appropriately identified and reported as child protection concerns and safety plans were developed and reviewed with the young people concerned. There was evidence that young people were also directed by staff to Tusla's *'Tell Us'* Complaint and Feedback Procedure or to their social worker where they were unhappy with outcome of their complaint. On review of the centre's young people's booklet the inspectors found there was no information for young people on accessing the Tusla's *'Tell Us'* Complaint and Feedback Procedure. The booklet must be updated in this regard. Following a review of the individual and key working sessions the inspectors found that information on the centre complaints procedure, Tusla's *'Tell Us'* and advocacy services was not completed with one of the young people who was in the centre six months at the time of the inspection.

The centre manager was the identified complaints officer. There was an updated complaints policy that had not been fully embedded at the time of the inspection. Staff interviewed were familiar with the complaint escalation pathway and the systems in place to record complaints. The regional director of services had scheduled a policy day for managers on 09th June and there were subsequent plans to disseminate information on updated policies to the staff team including the complaints policy. The regional director stated that the young person's booklet would be reviewed to ensure it is in line with the centre's updated complaints procedure. Two parents interviewed by the inspectors confirmed they had no complaints to date about the care of their respective child and stated they were provided with information about the service. They both confirmed that they would

be comfortable to raise any issue of concern or a complaint with the manager or key workers in the centre.

A new electronic system for maintaining a register/log of all complaints, compliments, incidents, child protection and welfare concerns, accidents and restrictive practices was being implemented at the time of the inspection. Minutes of team meetings evidenced that young people's meetings and complaints were mentioned. The records reviewed did not consistently outline the decisions taken or the learning identified.

A quality audit on complaints and feedback was undertaken in February 2023 which identified a number of recommendations relating to the recording and management of complaints in the centre. Inspectors found that the storage of information pertaining to the complaint and the resolution process was inconsistent and thus did not in all cases facilitate tracking of the complaint to conclusion. Some records were held in hard copy and some records were uploaded and stored electronically. A quality improvement plan (QIP) was developed incorporating the required actions from the quality audits undertaken between January and May 2023 however the however the QIP had not yet been completed by the manager who was on leave at the time of the inspection. There was evidence of governance and oversight of complaints within the monthly governance report. This report was completed by the centre manager and forwarded to the regional director for oversight. Additionally, complaints across the service were discussed at senior management team meetings.

An information corner in a communal area in the centre contained information on young people's rights including information on complaints, leaflet on Tusla's '*Tell Us*' Complaint and Feedback Procedure and the national advocacy group Empowering Young People in Care (EPIC). An advocate from EPIC had visited the centre on two occasions in December 2022 and met with the young people.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 16** **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 1.6**

standard in some respects only	
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must ensure they periodically review the group dynamics and identify ways in which they can encourage the young people to invest in the house meeting process. Additionally, the centre manager must ensure the team meetings reflect the decisions taken in response to issues raised at young people's house meetings.
- The centre manager must ensure that records of house meetings accurately reflect attendance at meetings.
- The centre manager must ensure that all records relating to complaints and the complaints resolution process are maintained in one location on the children's care records.
- The centre manager must ensure that information on Tusla's '*Tell Us*' Complaint and Feedback Procedure is included in the young person's handbook.
- The centre manager must ensure that key workers complete individual work with the two of the young people on the centre's complaints procedure for young people and provide them with information on Tusla's '*Tell Us*' Complaint and Feedback Procedure.
- The centre manager must complete the centre's quality improvement plan dated May 2023 in response to quality audits undertaken from January 2023.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The most updated care plan for one of the young people was not on file in the centre. The social worker confirmed this updated care plan was completed and was awaiting sign off by their team leader prior to forwarding to the centre. The care plans on file identified the health and development needs of the young people. Health and development needs were also set out on the individual placement plans with key work/individual work identified. However, the inspectors found that key and

individual work was not assigned to specific staff. The inspectors recommend that individual and key working is assigned to specific staff to complete to ensure tracking and accountability for undertaking specifics aspects of work with the young people. The staff maintained an electronic record of all appointments and the outcome of these appointments including medical, psychiatric, psychology, dental, ophthalmic and other specialist services as required. All young people had an allocated GP. There was evidence that the staff made a number of representations to the HSE to secure a GP for one of the young people. Medical assessments were undertaken as required. Medical consent was on file for the young people aged under 16 years of age. Immunisations were on file for all but one young person. The social worker stated they were forwarded to the centre however they were not on file at the time of the inspection. The centre manager must ensure a copy of the immunisations records is secured on file for the young person concerned.

There was evidence on the care records that managers and key workers highlighted to social workers the presenting health and development needs of the young people, at the child in care reviews and through regular communications with the social workers. The psychologist for one of the young people had facilitated additional training and guidance for the team with a focus on implementing a trauma informed approach to this child's care. The social worker indicated that only two staff members attended this meeting with the child's psychologist. The social worker was of the view that the team required additional training to further develop their trauma and attachment-based approach to working with this particular young person. The regional director confirmed there were plans for the services attachment specialist to work with the team in the coming months. Additionally, the inspectors found that training for the staff team to promote positive mental health and to respond to mental health issues in adolescence would be beneficial working with the cohort of young people referred to this centre. The centre manager and regional director of services must explore appropriate training for staff in the area of youth mental health.

The inspectors found that the young people were in receipt of appropriate assessments and/or specialist support to address their specific needs and to support their ongoing development. The parents who spoke with the inspectors stated that they were satisfied that the staff were responsive to the health and development needs of their child and kept them updated in this regard. Monthly progress reports outlined any health needs or appointments undertaken with the young people. Social workers interviewed were complimentary about the efforts made by the staff team to encourage and facilitate the young people to participate in sports and recreation

activities and to promote healthy lifestyles. The inspectors found that three of the four young people were involved in sports and recreation activities in the community and were in appropriate educational placements. There were plans in place to enrol the new resident in a training programme based on their individual interests. Weekly plans were developed in consultation with the young people and there was evidence that young people were kept busy and active.

The centre had a written medication policy. All staff received training in the safe administration of medication. There were some gaps in the medication administration system where, on a number of occasions, it was not clear if the young person was offered the medication or not or declined it. The stocktake section of the records were not completed consistently so it was unclear how staff accounted for medication stock. At the time of the inspection the centre were moving to a Kardex/MAR sheet for medication management. Training for staff in using the Kardex system was scheduled for staff. There was evidence that the medication management system was on agenda for discussion at upcoming policy day with managers. Staff guidance was to be issued on all templates/pro forma to be used. This will be a paper record system that will subsequently be uploaded on the electronic case management system at the end of each month. Additionally, the inspectors recommend that the policy in relation to the administration of PRN medication must be reviewed. The centre manager must secure written confirmation from the GP at the onset of the placement of all approved PRN medications for example cough syrup, paracetamol-based medications. The current practice required an appointment with a GP to authorise administration of over-the-counter medication on each occasion required. The inspectors found that this was not an appropriate use of public health services and an assessment of their health needs and the medication that may be administered should be approved and signed off by the GP for each young person as a matter of urgency.

There were policies and procedures in place in relation to young people smoking cigarettes that included education around the adverse impact of smoking on young people's health. At the time of the inspection three of the young people in the centre did not smoke cigarettes. The most recent resident stated they smoked and there was a procedure in place to secure written parental consent where young people smoked or Vaped.

Compliance with Regulation	
Regulation met	**Regulation 10**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that specific work is assigned to staff members to ensure accountability for work as set out in the monthly individual work schedule.
- The regional director of services must ensure the team have additional training to support the trauma and attachment-based approach and to support young people with their mental health.
- The centre manager must ensure that the medication administration records are up to date and fully completed by staff.
- The centre manager must ensure that at the onset of the placement all PRN medications for young people are signed off by their GP.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

The centre manager was on extended leave at the time of the inspection and the newly appointed deputy manager had taken on the role of acting manager for this period. There was evidence that additional supports were provided to the acting centre manager by two other senior centre managers within the service to support them with management tasks.

There were up to date job descriptions on each personnel file for the individual roles within the centre including the centre manager, deputy manager, team leader and social care worker.

The centre manager provided supervision for staff and had completed training to deliver supervision to staff. The supervision policy stated that staff would be subject to formal supervision every four to six weeks however supervision contracts indicated that supervision would occur every six to eight weeks. The centre manager needs to ensure the timeframes for supervision within the centre policy and the supervision contracts are aligned. The inspectors reviewed 10 staff supervision files including the centre manager's supervision records. Overall staff received regular supervision however supervisions occurred mostly every six to eight weeks not every four to six weeks as stated in the policy. There was however evidence that one new staff member did not receive supervision until three months after they commenced employment and one staff member only had two supervision sessions since the last inspection in July 2022. There was no note on their supervision files to explain these anomalies. All other staff had an average of six supervisions sessions over 12 months. The quality of supervision was found to be good overall with review of actions from previous supervision and key responsibilities, feedback, support and self-care, training and development included in the supervision process. Additionally, there was evidence that specific policies were reviewed with staff in supervision.

There was evidence that staff were not reliant on managers to make decisions and there was little activity in relation to staff availing of the out of hours on call support. Four staff members had resigned their positions since the last inspection and two new staff members were recruited to work on the team in the last 6 months. Staff recruitment and staff retention were discussed at senior management meetings.

Staff interviewed stated that the team worked well together and there was good support from colleagues and internal managers. There was evidence in supervision records that staff reflected on their learning and their practice. Staff highlighted to the inspectors that the current resources were stretched with staff resignations and the admission of a fourth young person. The worked staff rosters from January 2023 to date were reviewed by the inspectors and there was evidence that a number of staff from across the service had provided relief to provide a third staff member on each shift. Additionally, staff members had completed additional shifts to minimise the use of relief staff and the impact on the young people. At the time of the inspection one of the named relief staff was covering a significant number of hours however their availability was going to be more limited in coming months and another assigned relief staff for the centre had limited availability. Staff could access relief staff from across the wider service where there was availability. One shift over the six months was covered by an agency staff member. The current team comprised of eight staff who were all appropriately qualified in social care; two team leaders and

six social care workers however one of the social care workers had tendered their resignation and was working out their notice at the time of the inspection. The regional director of services confirmed to the inspectors they had identified additional staffing resources for the centre and were processing successful applicants at the time of the inspection. There was evidence that the regional director of services and the senior management team reviewed the staffing requirements for each centre within the service at the monthly senior management team meetings.

While staff had managed a number of challenging incidents in the centre the inspectors found that the young people were making good progress at the time of the inspection and the new resident was settling in well. This view was supported by parents and social workers interviewed. Incidents were managed well with support from internal managers and staff had worked hard to ensure the centre operated effectively in the absence of the centre manager. However, the inspectors found that staff morale was low and staff were dissatisfied with aspects of the operation of the centre. Following the inspection, the regional director of services facilitated a meeting with the team along with other external senior managers to acknowledge the work of the team and provide them with the opportunity to directly address and resolve their issues with external managers. The inspectors recommend that the regional director of services meet directly with the team periodically.

Training requirements for the teams were reviewed at senior management meetings and scheduled dates of training were notified to managers. Training requirements were identified within the supervision process.

Annual performance appraisals were undertaken however some performance appraisals for members of the team were not up to date. Two staff members had not undertaken an appraisal since 2021. One of the seven appraisals reviewed was not signed by both parties as required and one appraisal form had the year recorded on it but was not dated sufficiently to facilitate tracking for the next appraisal due. The regional director of services should consider additional training for managers to further enhance and develop the appraisal process for staff.

Supports to manage the impact of working in the centre were identified by staff as supervision, de-briefing following incidents and access to an independent counselling service paid for by the company.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
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 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre must ensure that staff supervision is carried out in line with policy and that newly recruited staff receive regular supervision when they commence employment in the centre.
- The centre manager must ensure that performance appraisals are conducted with staff at least once a year.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure they periodically review the group dynamics and identify ways in which they can encourage the young people to invest in the house meeting process. Additionally, the centre manager must ensure the team meetings reflect the decisions taken in response to issues raised at young people's house meetings.	This is currently not an issue in the centre following the planned discharge of one young person. The centre manager and staff team will continually review group dynamics going forward and encourage young people to invest in the house meeting process. House meetings will now occur the day prior to the team meetings and decisions made in response to the issues raised at the house meeting will be noted the minutes of the team meetings. Commencing 18th July 2023.	The centre manager will oversee this process in house. The director of operations, who is now overseeing the centre, will be in attendance at team meetings quarterly, at a minimum, to ensure this process is in place.
	The centre manager must ensure that records of house meetings accurately reflect attendance at meetings.	Going forward this should not be an issue, however should there be an occasion where young people cannot complete the house meetings together the centre manager will ensure that the meeting	The centre manager will sign off on house meeting minutes to ensure the accurately reflect those that were in attendance. This will be overseen by the director of services and reviewed by the quality

		minutes accurately reflect this. Commencing July 2023	assurance co-ordinator as part of the centre's audit process.
	The centre manager must ensure that all records relating to complaints and the complaints resolution process are maintained in one location on the children's care records.	The centre manager will ensure that all records relating to complaints are maintained on the young persons file on the centre's electronic recording system. This will be discussed at the team meeting on the 14.07.22.	All complaints will be reviewed by the director of operations. This will also be reviewed by the quality assurance co-ordinator as part of the centre's audit process.
	The centre manager must ensure that information on Tusla's '*Tell Us*' Complaint and Feedback Procedure is included in the young person's handbook.	The centre manager will ensure that the young person's handbook is reviewed to include information on Tusla's complaint and feedback procedure. To be completed by August 2023.	The Director of services will sign off on this once completed. The young person's handbook will be reviewed annually as part of the organisation's senior management meetings going forward.
	The centre manager must ensure that key workers complete individual work with the two of the young people on the centre's complaints procedure for young people and provide them with information on Tusla's '*Tell Us*' Complaint and Feedback Procedure.	The centre manager has assigned this to keyworkers and this will be completed by the 21.07.23.	The centre manager will ensure that this is included, as standard, as part of key working upon admission of a new young person. This will be overseen by the director of services. This will be reviewed as part of the centres audit process.

	The centre manager must complete the centre's quality improvement plan dated May 2023 in response to quality audits undertaken from January 2023.	This will be completed by 31st of August 2023.	The centre's quality improvement plan will be reviewed monthly by the director of operations. Any outstanding actions will be raised as part of the centre managers supervision and a timeline for completion will be established.
4	The centre manager must ensure that specific work is assigned to staff members to ensure accountability for work as set out in the monthly individual work schedule. The regional director of services must ensure the team have additional training to support the trauma and attachment-based approach and to support young people with their mental health. The centre manager must ensure that the medication administration records are up to date and fully completed by staff.	This has been completed. Going forward keyworkers will assign specific staff to complete set individual work with young people in the individual work schedule to ensure accountability. The director of operations, who is now overseeing the centre, will ensure that the additional supports for the team in relation to the trauma and attachment-based approach required to support the young people with their mental health are sourced. This will commence August 2023. This has been completed and a new medication management policy has been implemented in the centre. Completed June 2023.	This will be overseen by the centre's management team and discussed in staff supervision. Approach to care will be discussed as a standing item on the team meeting agenda. Centre manager will ensure all staff are available to attend trainings and maintain a list of attendance which will be overseen by the director of operations. This will be overseen by the centre's management team, any issues will be escalated to the director of operations. This will be reviewed regularly as part of the centre's audit process.

	The centre manager must ensure that at the onset of the placement all PRN medications for young people are signed off by their GP.	This has been implemented as part of the centre's new medication management policy. Completed June 2023.	This process will be overseen by the centre's management team.
6	The centre must ensure that staff supervision is carried out in line with policy and that newly recruited staff receive regular supervision when they commence employment in the centre.	The centre manager will ensure that supervision occurs within the timeframe of the organisations policy and more frequently for new staff. Commenced June 2022.	Supervision will be reviewed as part of the centre's monthly governance and oversight report which is overseen by the director of operations and the organisation's quality manager. Any delay in completing supervisions with staff will be discussed with the centre's management team.
	The centre manager must ensure that performance appraisals are conducted with staff at least once a year.	The centre manager will ensure that the two outstanding appraisals are completed and that going forward all appraisals are conducted annually. To be completed by August 2023.	Staff appraisals will be reviewed as part of the centre's monthly governance and oversight report which is overseen by the director of operations and the organisation's quality manager.