An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 024

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Cottage Homes Child and Family Services**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Unannounced Inspection**
Date of inspection:	**06th, 07th & 08th March 2023**
Registration Status:	**Registered from 31st October 2021 to 31st October 2024**
Inspection Team:	**Ciara Nangle** **Janice Ryan**
Date Report Issued:	**29th June 2023**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 2009. At the time of this inspection the centre was in its fifth registration cycle and was in year two of the cycle. The centre was registered without attached conditions from 31st October 2021 to the 31ST October 2024.

The centre was registered as a multi occupancy service to provide care to four young people from age thirteen and seventeen on admission. The model of care was described as relationship based. 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
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 5th May 2023 and to the relevant social work departments on the same date. 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 19th May 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: 024 without attached conditions from the 31st October 2021 to 31st October 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

There was a centre manager in post who was also the named person in charge. They were aware of their roles in this regard and were also the designated liaison person for the service. Leadership was evidenced throughout documentation reviewed as part of this inspection including team meeting records, management meetings and young people's records. The centre held weekly team meetings where information on young people, issues arising for the team and centre were discussed and weekly plans made. These were attended by the centre manager, deputy manager and full staff team.

There was clearly defined governance arrangements in place at the time of inspection. The centre manager reported to the Director of Service, who in turn reported to the Board of Management through monthly board meetings. The centre manager also attended these meetings on a bi-monthly basis and on occasion members of the board visited the centre or attended team meetings.

The Director of Service had responsibility for governance and oversight within the centre and regularly visited the centre and attended staff meetings on occasion. They also completed themed audits within the centre and compiled an annual compliance report. Staff in interview were aware of the role of the Director of Service and their oversight of centre documentation was evident in the sample of young people's records reviewed.

The was a service level agreement in place with the relevant funding body and updates in regards to the service were provided as required.

The organisation was in the process of implementing a set of reviewed policy and procedures which had been reviewed following the last inspection in April 2022.

Some of these had been introduced and a schedule was in place for the remaining policies to be rolled out. These policies were aligned to the National Standards for Residential Care, 2018 (HIQA). Inspectors sighted evidence of these reviewed policies being discussed during team meetings, with team members being required to read policies in advance of meetings to ensure understanding and facilitate discussion. The centre manager must ensure that all staff are trained in the remaining policies and procedures in line with their implementation schedule.

Inspectors found that risk management and safety planning required improvement to ensure that information is accurately and appropriately recorded, and safety plans are in place when required.

The centre had a risk management framework in place at the time of inspection. This included the use of an organisational risk register, centre risk registers and individual risk assessments specific to the young people. Within the centre register inspectors saw evidence of risks being reviewed and closed when appropriate. The register did not contain details of the dates the risk was last reviewed however these are included on the individual risk assessments.

On review of the centre register, inspectors noted that some risks within the centre had not been included on the centre register and at times individual risk assessments for young people did not accurately detail the risk or the controls in place. Additionally, inspectors did not find associated safety plans for some identified risks when these were necessitated. Where safety plans were in place, they were not formatted consistently across the young people's records and did not include all controls in place or highlight all risks to the young people which presented as a safeguarding issue.

Inspectors found that there was a risk in relation to one young person associated with the use of the centres 'Den'. This was a wooden garden shed located in the back garden which had been converted into a recreational space for the young people. One young person was permitted time in the 'den' with their peer in which the centre had identified concerns around illegal substance misuse and possession of illegal substances. The centre had implemented controls to promote safety which included increased supervision levels and physical checks; however, these safety measures were agreed during a team meeting and inspectors did not see evidence of these measures contained within a risk assessment or safety plan on the young person's care records.

Additionally, inspectors noted that when the centre had implemented restrictive practices, there was no corresponding risk assessments in place. At the time of inspection, the centre was not utilising any restrictive practices, however, should they be required again in the future these must be risk assessed and implemented in line with the centre's policy.

Although the centre had a procedure in place for the review of significant events this process did not allow for an analysis of patterns or trends in events within the centre or for the young people. This was identified in interview with the Director of Services who explained that they were in the process of reviewing this procedure to ensure there was governance and oversight of any patterns and trends. The Director of services must ensure that this new procedure is implemented to allow for good oversight and governance of these patterns and the development of best care practices within the centre.

The Director of Services maintained responsibility for the regulation and compliance of the service in line with National Standards for Residential Care, 2018 (HIQA). Themed audits were completed by the director of services, and following on from these, an action plan to address deficits identified was developed and returned to the Director of Services by the centre manager. The centre had also availed of an external audit in relation to complaints since the last inspection and has planned for a further external audit under Theme Three of the National Standards to be completed in the coming months.

On review of the themed audits completed by the Director of Service and associated action plans, inspections found that while it was detailed in some aspects of the report, the outcome of the audit and action required, requires further improvement as there was limited detail to address the deficits identified, and at times inspectors found it difficult to see the completion of some of the identified deficits.

The centre manager also completed monthly governance reports which are sent to the Director of Services. These reports are also aligned to the Themes of the National Standards for Residential Care, 2018 (HIQA). On review of a sample of these reports, inspectors noted that there was significant detail included in relation to the centre's compliance however at times actions were identified within the body of the report were not detailed within the associated action plan. Inspectors ascertained from a review of a sample of supervision records that that supervision wasn't always occurring in line with policy, however this was not captured within these governance reports. Additionally, within these reports, there was no mechanism for the Director

of services to track these actions and this requires improvement. The Director of Services and centre manager must ensure that supervision occurs in line with policy and that governance mechanisms are robust within the service to ensure best practice.

At the time of inspection, the internal management structure consisted of a centre manager and a deputy manager. The management structure was appropriate to the size and function of the centre.

At the time of inspection there was an up to date delegation log in place. There was details of the roles delegated to alternative members of the team and time frames around these. There was also a document in place with set out the division of tasks on a permanent basis between the centre manager, deputy manager and the social care leaders.

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

Compliance with standards	
Practices met the required standard	**Not all standards were assessed within this inspection**
Practices met the required standard in some respects only	**5.2**
Practices did not meet the required standard	**Not all standards were assessed within this inspection**

Actions required

- The registered provider must review the risk management framework and ensure that all risks are appropriately categorized, recorded and appropriate safety plans are in place.
- The centre manager must ensure that all care directions/safety plans are recorded within young people's files.
- The registered provider must ensure that all staff are trained in the use of the risk management framework.
- The centre must ensure that all restrictive practices within the centre have associated risk assessments in place in line with the centre's policy, and that these practices remain in place for the shortest time possible and are reviewed regularly.

- The centre manager must ensure that all staff are trained in the remaining policies and procedures in line with their implementation schedule.
- The registered provider must review the Significant Event Review System to ensure it is effective in practice and allows for oversight of trends and patterns within the centre.
- The centre manager must ensure that supervision of staff occurs in line with policy.
- The registered provider must ensure that audits completed and action plans put in place include all identified actions and are reviewed and tracked to ensure completion of actions. This needs to be demonstrated across centre records.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Workforce planning for the centre was completed by the centre manager and Director of Services and it was discussed at management and senior management meetings. The team were updated on recruitment during team meetings and annual leave was planned for throughout the year.

The centre implemented a daily roster pattern of two sleep over shifts and one day shift. The centre was operating with four social care leaders. At the time of inspection, one of the social care leaders was working as a social care worker for a period of approximately four weeks to induct them into the service as they had only commenced in the service the week prior to inspection. Following the induction period, they would assume the roles and responsibilities associated with the social care leader post. Another of the social care leaders did not hold any additional responsibilities. The centre also had five social care workers, in addition to the centre manager and deputy manager. The centre had a vacant post for one social care worker and the centre manager and Director of Services were actively recruiting for this post with interviews scheduled for the week following the inspection. The centre also had access to a panel of relief staff which was utilised by both centres in the organisation to support the core team.

At times the centre had to rely on agency staff to fill the rota as this could not be maintained by the core team and relief staff. This impacted on the consistency in care for the young people in the centre. The centre had recently recruited a further relief social care worker, who was completing the relevant recruitment checks. When the vacant social care worker post is filled the centre will have sufficient staff to ensure the needs of the young people are met however ongoing efforts to successfully fill this vacancy are required.

The staff team in place had the necessary qualifications for the role. In interview staff demonstrated an understanding of their roles and responsibilities. On the sample of personnel files reviewed, there was appropriate job descriptions on file and the staff had the appropriate qualifications. The team had completed the core trainings required by the centre and were trained in a model of behavioural management. The centre tracked the training of the staff team to ensure that any deficits were rectified in a timely manner.

The organisation had incentives in place in regard to the recruitment of staff however were limited in what these incentives could be due to budgetary constraints. They had implemented schemes such as “refer a friend” and were actively approaching universities to try to recruit directly from suitability qualified graduates. They also offered team days off site and team facilitation throughout the year. The centre was somewhat limited due to issues with pay terms and conditions due to their status as a voluntary agency and this impacted on the package they could offer to potential staff. This was an issue the director of services was regularly raising with the relevant funding bodies.

The centre had an on-call policy in place. A rota was in place which included social care leaders, centre managers, deputy managers and the director of services. The policy had recently been amended following an inspection in another centre within the organisation to ensure that social care leaders were not on-call to themselves which had been the practice that was in place, and this was in the process of being introduced across the service. Additionally, the service had also introduced a practice of recording any contact with the manager on call in the young people’s Significant Event Records (SEN). Inspectors saw evidence of this change being communicated to the staff team within a team meeting. At the time of inspection there had not yet been an SEN which necessitated contact with on-call since this amendment was introduced so inspectors could not determine if this had been effectively implemented into practice. The service must ensure that all new procedures and

changes to the on-call policy are introduced within the centre and staff are aware of these changes.

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 were assessed as part of this inspection**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards were assessed as part of this inspection**

Actions required

- The registered provider must continue to actively recruit an additional staff member to ensure that the centre has sufficient staff in place to provide consistency in care to the young people.
- The registered provider must ensure that the changes made to the on-call policy and procedures are effectively brought into practice within the centre and that all staff are trained in the amended policy.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider must review the risk management framework and ensure that all risks are appropriately categorized, recorded and appropriate safety plans are in place.	Management with managers and Director have reviewed the Risk Management Framework, are in the process of drawing up guidance document for staff and plan a training day for staff members in relation to the risk management framework.	Staff training Ongoing review of risks at managers meetings Risks are reviewed as part of new case management meetings with keyworkers and the Deputy Manager every 4 – 6 weeks. Risk assessments are reviewed every 5 weeks in line with young people's paperwork.
	The centre manager must ensure that all care directions/safety plans are recorded within young people's files.	The Safety Plan template has been introduced to the staff team and currently is in place where necessary for young people.	These are reviewed in line with young peoples 5-week paperwork. Reviewed as part of new case management meetings with keyworkers and the Deputy manager every 4 – 6 weeks.
	The registered provider must ensure that all staff are trained in the use of the risk management framework.	Staff training planned for 20th June on the risk management framework.	This presentation will reviewed with new staff members as part of the induction process.

	The centre must ensure that all restrictive practices within the centre have associated risk assessments in place in line with the centre's policy, and that these practices remain in place for the shortest time possible and are reviewed regularly.	Risk Assessments have been drawn up for all restrictive practices. Risk assessments have been added to young people's risk register. Continue to review restrictive practices weekly at team meetings.	As restrictive practice is put in place a risk assessment will be drawn up and added to the risk register. This will be closed once restrictive practice is removed. Note has been placed on restrictive practice log to remind staff to draw up risk assessment if noting a restrictive practice in the log. Manager will review this as part of their monthly governance audit.
	The registered provider must ensure that all staff are trained in the new policies and procedures.	Ongoing roll out of policies and review at team meetings in line with schedule	Continue roll out and review of policies at team meetings. Policy review schedule in place.
	The registered provider must review the Significant Event Review System to ensure it is effective in practice and allows for oversight of trends and patterns within the centre.	Review of the purpose and scope of the internal SEN review group to take place on the 22nd of May by the Director and Managers.	Review process of internal SEN review group on a six-monthly basis. Receiving feedback from staff member sitting on the group before rotating role to another staff member who is then shown the process of how the SEN group operates.
	The centre manager must ensure that supervision of staff occurs in line with policy.	At the beginning of each month the manager checks supervision dates to ensure they are scheduled. Supervision to occur every 4-6 weeks.	Next supervision date to be scheduled at the end of each supervision. This review at the start of each month.

	The registered provider must ensure that audits completed, and action plans put in place include all identified actions and are reviewed and tracked to ensure completion of actions. This needs to be demonstrated across centre records.	The Manager will provide an update on progress made in relation to action plans and the Director will track process through the centre records. New form drawn up to collate all actions from audits.	The director will track the completion of actions through the centre records.
6	The registered provider must continue to actively recruit an additional staff member to ensure that the centre has sufficient staff in place to provide consistency in care to the young people. The registered provider must ensure that the changes made to the on-call policy and procedures are effectively brought into practice within the centre and that all staff are trained in the amended policy.	Ongoing recruitment in process in place. Engaged with agencies to source suitably qualified staff. Incentives in place for staff to recruit new staff members. Reviewed criteria for applicants to broaden the scope. We are reviewing how the On call system is utilised to ensure we get the best from the system with the least amount of impact on the management team who are not renumerated for this task.	Ongoing recruitment campaign in place, boosting the relief panel to ensure continuity of staffing to fill vacancies. Continue to negotiate with Tusla around funding to pay for On call as this is currently not provided as part of our budget.