An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 026

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Crosscare**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Date of inspection:	**13th & 14th December 2022**
Registration Status:	**Registered from 30th June 2020 to 30th June 2023**
Inspection Team:	**Lisa Tobin** **Eileen Woods**
Date Report Issued:	**15th March 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 on the 30th June 2002. At the time of this inspection the centre was in its seventh registration and was in year three of the cycle. The centre was registered without attached conditions from 30th June 2020 to 30th June 2023.

The centre was registered as a multi-occupancy service. The centre was registered to accommodate five young people from age twelve to eighteen years on a short to medium term basis. The centre accepted referrals through the Tusla Crisis Intervention Service. Their model of care was described as building relationships to support young people utilising a restorative approach and identification of individual needs. The centre maintained a statement of the values of the governing voluntary body of 'love, respect and excellence' as the guiding principles of their purpose and function. 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
3: Safe Care and Support	3.2
4: Health, Wellbeing and Development	4.2

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 25th January 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 1st March 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: 026 without attached conditions from the 30th June 2020 to the 30th June 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations 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.

Inspectors saw many ways in which the young people's voices were captured while completing the file review. Individual work, young person's placement plans and the measuring outcomes document all showed where their voices were captured. Inspectors met with one young person who spoke positively about their relationship with the care team and about the supports available to them from their keyworker and the centre management. Inspectors found that the daily logs showed little evidence of recording the young person's voice and the dedicated section for same required review with the team as to how this section can be completed effectively.

There was a policy and procedure on complaints in place which was updated in 2022 as an outcome of the annual inspection in 2021. This inspection identified the need to bring the policies in line with the National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors found that the complaints procedures were known by staff when discussed during their interviews. Staff were knowledgeable of the escalation process depending on the type of complaint made. Inspectors saw that there were two complaints on the register since the last inspection in November 2021 and both were linked with issues external to the centre. The centre manager spoke of the use of key working, individual work and general discussion to deal with any non-notifiable complaints. Inspectors saw this while completing the file review where young people were able to address any issues they had with the team. Young people were supported by the care team to make complaints. Inspectors saw where young people were offered complaints forms if they had an issue, sometimes they refused, and the issues were addressed through individual work or at the boys' meetings. Inspectors saw complaints were discussed at team meetings when they came up.

Inspectors reviewed a blank complaint form as there were no complaints for the current young people in the centre. Inspectors found that the form was lacking a section to record the outcome of the complaint and feedback from the young person

on whether they were satisfied or not and also a closure date to show the complaint was responded to in line with policy timeline.

Young people were informed of external services available to them such as Empowering Young People in Care (EPIC), Ombudsman for Children (OCO) and "*Tell Us*", Tusla's complaints portal and they were utilised when required. EPIC was currently linking with one young person regarding support for aftercare. The young people were informed of the complaints process during their induction as part of their admission and in the young person's booklet.

Inspectors reviewed the minutes from the boys' meeting which were due to occur weekly in line with centre policy. However, inspectors noted these were not occurring weekly and saw that there had been a gap of six weeks at one point. This was at times due to the boys not being present in the centre on the specific day, but no alternative was seen. The centre manager must ensure that young people are informed of the outcomes from their queries or requests at the boys' meetings.

Inspectors found when reviewing the young people's questionnaires that they were able to identify someone they could talk to if they had any issues namely key workers, care staff, family or social workers. One young person stated they were not happy with the level of contact with their family, and another was not happy about the lack of social work availability. Both of these issues were being followed up by the team, through Tusla Tell Us system and by linking with the social work department.

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 in some respects only	**Standard 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must update the complaints form to include the outcome of the complaint, feedback from the young person and a closure date.

- The centre manager must ensure that feedback is provided to the young people and documented following requests or issues that arise at the boy's meetings.

Regulation 5: Care practices and operational policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

There were a number of policies and procedures in place to help promote positive behaviour with the young people. Some of these were supporting positive behaviour, managing and responding to challenging behaviour and restrictive practices. Inspectors saw that policies were discussed at team meetings and at team leader meetings.

During interviews the staff members discussed the relationship-based approach model of care they used and how this was the basis of establishing trust and transparency with the young people they cared for. Included in this model and response, was a restorative practice approach intertwined which enabled the team to work with the young people in a way that worked towards a more solution focused response to their issues and promoted positive behaviour. Staff had been provided with training on the model of care and some staff had completed the restorative practice approach training and further training will be provided as updates are added to the approach. Inspectors found that while the staff had good knowledge of the processes for restorative practice, it wasn't as evident in the associated paperwork. The centre manager must ensure that the corresponding documents are referencing the use of the restorative approach that was undertaken with the young people.

Inspectors reviewed the training log and found it was not up to date with accurate information. This was resubmitted to inspectors and gaps were identified in particular for the restorative practice training with ten staff requiring this. The training log did not list all staff members on the tracker that were identified on the staff information sheet. There were gaps noted in training in a recognised model of behaviour management. Centre management must ensure all training completed is recorded accurately and up to date on a system that can be tracked easily.

Inspectors saw relevant guiding documents utilised to support behaviour management including placement plans, safety plans, individual risk assessments, collective preadmission risk assessments (CPARA), absent management plans (AMP) and individual crisis management plans (ICMPs). Inspectors found that the goals linked to the placement plans and the practical steps were clearly identified for the majority of the young people. Inspectors saw that one young person was reported as absent at risk repeatedly and was linked with ongoing low mood and suicidal ideation. Staff remained in contact with this young person and followed their AMP. Inspectors were informed there was no allocated social worker for this young person and therefore it was not possible to link with the social work department to review the parameters for changes to the young person's AMP. Management may need to review their own response to cases where there was a deficit in social work allocation and identify what would be the most suitable response to the young person's needs.

Inspectors found that the staff were skilled and trained appropriately to work with the young people and respond to any issues that arose. Inspectors saw detailed individual work completed with the young people around addressing their current issues and offered supports from the team and from the availability of wider community's specialist supports. Inspectors saw how the staff were responding to and working with a new resident at their pace and looking at ways in which they could approach situations in a manner that was comfortable and considerate to the young person's disabilities, while continuing to build relationships with the young person.

Inspectors saw that given the nature of the service and the crisis response to some placements, the centre at times struggled to gain access to all relevant information of the young people. This at times led to difficulties within placements in ascertaining what pieces of work were required to be completed as the team were awaiting direction from social work. Inspectors saw evidence of emails sent to social workers requesting any relevant documents required for the young people's files.

Inspectors saw that the review of management of behaviour that challenges was undertaken in team meetings, during significant event review group meetings (SERG) and at strategy meetings. Inspectors found that the SERG reviews were well detailed regarding an analysis of behaviours, however, it lacked the oversight for learning and improvement in practice for the team. Internal audits were undertaken by the team against the standards and theme 3 was audited in June 2022. Two questions were left blank on the audit and the main action attached to 3.2 identified

the requirement of updated policies, which was undertaken in 2022. Inspectors did not see any external audits relating to behaviour that challenges undertaken. Senior management must ensure this practice is undertaken as identified in the National standards for Children' s Residential Centres 2018 (HIQA).

There was a restrictive practice policy in place and staff were aware of what restrictions were in place in the centre. Some restrictions were identified as general household rules such as the kitchen and sitting room locked at night and reduced Wi-Fi access, whereas staff were also able to identify young person specific restriction such as no access to a smartphone and undertaking room searches if there was any suspicion of a health and safety issue. Inspectors did not see the discussion or review of restrictive practices noted in the sample of team meeting minutes reviewed.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must ensure that the young people's documents reflect the restorative approach processes been undertaken by the staff.
- The centre management must ensure all staff receive training in the model of care and in a recognised model of behaviour management.
- The centre management must ensure that the training log is up to date with all staff information and training identified and can be easily tracked.
- The centre manager and senior team must review the SERG processes to ensure the practical element of learning and improvements are addressed for the staff.
- The centre manager and senior manager must ensure that external audits relating to behaviours that challenge are undertaken in line with the National standards for Children' s Residential Centres 2018 (HIQA).

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.

Inspectors found that two of the five boys had an up-to-date care plan on file. Two of those boys had recently been admitted to the centre. Inspectors saw there were requests on file from staff to social workers for the young people's care plans to be forwarded or for dates for child in care reviews (CICR) to be undertaken. For those who had care plans on file, inspectors saw their health needs were identified and any further supports required were also noted. Three young people had undertaken their medical into care with their general practitioner (GP) and attended the dentist for a check-up. There were two new residents who were waiting for their medical into care to be completed. Inspectors did not see any reference to optical care for the young people which must also be addressed.

During interviews inspectors were informed that staff had undertaken first aid training and training related to mental health awareness. The training logs made available to inspectors showed nine out of seventeen staff members had completed first aid and no dates were linked to assist training for any staff member. As referred to earlier the training log must show the relevant details of the training undertaken by the team.

Inspectors found that the young people had a GP available to them, some used the local GP and others remained with their family GP. Inspectors saw evidence of appointments made for the young people for the GP and for the dentist and works carried out as needed. Four of the five young people had a valid medical card. The one young person without a medical card was being supported by the staff to address the ongoing issue.

Inspectors were informed that generally the relationship with social worker's was positive and they worked together to meet the young people's needs in particular when any specialist services were required. Inspectors found that when there were issues with contacting a social worker, the centre manager escalated the issue within the social work department and with their senior manager. Young people had access

to a range of specialist services including child adolescent mental health services (CAMHS), Lucena, counselling services and services supporting substance misuse. Staff had supports available to them with additional training when identified as beneficial for addressing the needs of the young people. Upcoming identified training related to ASD, ADHD and training in the use of an EpiPen for an allergy had been identified by the team to help assist with the current young people's needs.

There was a medication management policy in place and staff stated they had completed training on HSE land however inspectors did not see any reference to this on the training log. Inspectors noted that there were staff members that required first aid training. It was not clear to inspectors during the medical file review if a young person held their own medication or if it was administered by staff. Inspectors found that medication forms were not completed appropriately in full. Inspectors found it was not possible to identify the quantity of medication remaining for one young person with the medication administration logs that were currently in place. A review of the management of medication was required to ensure there was appropriate oversight of the administration and management of medication. Inspectors saw that theme four had been completed by staff in an audit however did not capture the issues identified by inspectors.

Compliance with regulations	
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 the ophthalmic needs of the young people are addressed as part of their medical into care.
- The centre manager must ensure there is oversight of the administration and medication of management.
- The centre manager must ensure that all staff have competed their first aid training.

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 update the complaints form to include the outcome of the complaint, feedback from the young person and a closure date. The centre manager must ensure that feedback is provided to the young people and documented following requests or issues that arise at the boy's meetings.	The centre manager will update the complaints form to include the outcome of the complaint feedback from the young person and a closure date. To be completed by 31st March 2023. The centre manager will ensure that feedback is provided to the young people and documented following requests or issues that arise at the boy's meetings. This will be documented in individual works, team meeting minutes and minutes from the boy's meetings. This will be allocated to a team member or management to feedback on the day following the team meeting. This will be implemented immediately.	To be reviewed during internal audits completed by the centre management and senior management every quarter. Overview by the centre management through daily signoffs and reviewing of follow-ups from team meeting minutes. To be reviewed quarterly by the centre management and senior management during audits.
3	The centre manager must ensure that the young people's documents reflect	Reminding team at Team meeting on 14.02.23 to continue to engage in	To be reviewed during internal audits quarterly and discussed at team meetings.

	the restorative approach processes been undertaken by the staff.	restorative conversations and document these.	
	The centre management must ensure all staff receive training in the model of care and in a recognised model of behaviour management.	The centre manager will ensure that all staff receive training in the model of care and recognised model of behaviour management. The staff will be actively involved in developing this with Practice and development attending team meeting on 21.02.23. TCI training taking place on 28th, 29th 31st of March for staff who have not completed this. Refresher in TCI taking place on 14.03.23 for all other staff.	Centre manager to ensure this is reflected in the training log and updated accordingly.
	The centre management must ensure that the training log is up to date with all staff information and training identified and can be easily tracked.	The centre manager will ensure that the training log is kept up to date. Layout of log to be amended to include expiry dates of training. To be completed by 31st of March 2023.	Centre manager to ensure this is reflected in the training log and updated accordingly.
	The centre manager and senior team must review the SERG processes to ensure the practical element of learning and improvements are addressed for the staff.	Feedback from SERG will be given by centre management at first team meeting following SERG. This took place on 24th of January 2023. Further learning and development can be addressed at	The SERG process to ensure practical element and improvements will be discussed at each team meeting following the SERG.

		supervisions. Feedback from team will be added to SERG minutes prior to sending to senior management.	
	The centre manager and senior manager must ensure that external audits relating to behaviours that challenge are undertaken in line with the National standards for Children' s Residential Centres 2018 (HIQA).	Practice and development manager for Crosscare will join SERG group from 19th of April 2023. A section on reviewing approaches to behaviours will be added to SERG minutes from 19th of April 2023, including actions needed. Centre management will be responsible for overseeing any actions or recommendations made.	During each SERG process current behaviours will be discussed and approaches that have worked or not worked with y/p will be noted. These will be identified to ensure effective change is put forward in work practices.
4	The centre manager must ensure that the ophthalmic needs of the young people are addressed as part of their medical into care.	The centre manager will ensure that all young people new to the centre will have their ophthalmic needs included in their medical into care. This will be put in place for all new admissions going forward.	To be reviewed during internal audits. This will be included on each new young person's induction checklist and noted as a topic on exploratory and induction meetings.
	The centre manager must ensure there is oversight of the administration and medication of management.	The centre manager will ensure there is oversight of the administration and medication management. A new section will be added to medication sheet to include management signing. A medication officer will be appointed to	Centre manager will ensure medication management is recorded and they are completed and signed off for the purpose of governance, oversight and tracking.

	The centre manager must ensure that all staff have competed their first aid training.	oversee and complete medication reviews. This will be completed by 31st March 2023. Management have been in touch with practice and development regarding first aid training. They are seeking external trainers to complete this. Awaiting date- will be completed this year. There are two hospitals in close proximity to the house if any young person requires urgent medical attention. D-Doc is close by also.	Centre manager to monitor the training log to note refresher dates required to ensure governance of ongoing First Aid training.