An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 053

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Rainbows Community Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**09th & 10th November 2021**
Registration Status:	**Registered from 31st March 2019 to 31st March 2022**
Inspection Team:	**Lisa Tobin** **Sharon Mc Loughlin**
Date Report Issued:	**19th January 2022**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 31st March 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 31st March 2019 to 31st March 2022.

The centre was registered to provide accommodation to four young people of both genders from age sixteen to nineteen years in their own apartment coupled with on-site team supports. Their model of care was described as relationship based with an understanding of attachment and strong core working knowledge of the skills and resilience required for the next stage in the young people's lives. The team was utilising a new model of care, *Daily Life Events*, which looked at everyday tasks and creating positive experiences from them. There were three 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
2: Effective Care and Support	2.2
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 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. The inspection was blended with a combination of on site file review and interviews on MS Teams with the staff.

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 15th December 2021. 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 4th January 2022. 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: = 053 without attached conditions from the 31st March 2019 to the 31st March 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

Inspectors found that all three young people had their care plan or aftercare plan in place and were up to date in their files. It was evident that placement plans, and goals were aligned to the care planning actions and aftercare plan goals. Inspectors were informed the centre planned to change the current format of the placement plans in January 2022 to a more streamlined approach in identifying goals without the analysis at the beginning of the document. This process will mirror the format in the sister house within the organisation which management have found more effective for tracking progress.

Inspectors reviewed the placement plan documents and saw they were updated monthly by keyworkers. The placement plans were discussed at team meetings which enabled the team to have awareness of what goals were in place for the coming month for the young people and to voice any additional goals that required implementation. Goals were identified for each young person and the key working and individual work completed with the young people addressed the relevant goals from the placement plans and the aftercare plans. If goals were unmet or required further work, they were brought forward to the plans for the following month. Records of placement planning meetings evidenced that one young person attended all meetings relevant to them. The other young people attended in part at their placement meetings or used the key workers to advocate on their behalf. The young people completed review forms to ensure their voice was heard. Keyworkers or management provided feedback to the young people if they weren't in attendance at the reviews. Inspectors reviewed the format and details of the placement plans and noted there was a deficit in documenting how the staff completed/undertake the actions with the young people. Inspectors noted the placement plans read as a retrospective document rather than a planning document. Further information was required in the placement plans that addressed the work the staff intended to undertake.

External supports were made available to the young people including National inter-agency Prevention Programme (NIAPP), Garda Diversion programme, mental health

services within HSE, community gardai, Child Adolescent Mental Health Services (CAMHS) and Substance Use Service for Teens (SUST). Some young people were yet to engage in the services available, however the staff were available to facilitate the appointments and linked with the services for advice, support and guidance around the young people's issues.

Inspectors saw evidence of communication with the social workers and aftercare workers. Positive feedback was given during interview about the effective communication and the work that was carried out with the young people in the centre addressing the goals identified for the young people and preparing them for independent living. The staff linked in weekly with social workers and aftercare workers by phone and email and gave updates on the young people.

Compliance with Regulation	
Regulation met	**Regulation 5**
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 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that the placement plans document details how the work was intended on being completed with the young people.

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.

Leadership was demonstrated by the centre manager and the deputy manager through their oversight of documents, leading team meetings, supervision and support for the staff team. Inspectors saw oversight from the director of services during file review also. Inspectors saw improvements made within the centre since the last inspection and how the recommendations had been implemented by the management team to have greater governance and management arrangements within the centre.

Inspectors noted there was governance arrangements and structures in place with audits completed internally and externally. There were two audit systems in place, one by the centre manager and a second by the director of service. The centre manager audits were against the old standards and were due to be brought in line with the National Standards for Children's Residential Centres 2018 (HIQA), early in 2022. The audits required update around further oversight in the centre aligned to the relevant standards. The centre must ensure that the audits identify where the gaps were in the service, actions addressing these and the person/people responsible for undertaking them. The audit must be linked with the risk registers and with the service improvement plan to bring together the information which guides the service moving forward.

The director of service completed audits that were reviewed by inspectors. Theses audits were against the National Standards for Children's Residential Centres, 2018 (HIQA), and themes 1, 2 and 6 were completed to date. These audits showed where the centre was compliant and identified where there was further work required. In May 2021 the director of service had completed an annual report on the service, which gave good oversight of what had happened in the organisation in the last year. However, the report did not give details of any service improvement plans/goals that were being looked at/addressed for the coming year.

There was a new funding contract in place with Tusla from July 2021 – 2024. Six monthly reports were required for Tusla to show compliance with the relevant legislation and standards.

The centre manager was the person in charge with overall accountability for the centre. The policies and procedures were updated and amended in September 2021 to include a policy regarding the procedure of archiving young people's files to Tusla, data protection and deletion of information. The inspectors were informed that the policies and procedures were currently being updated by the centre manager to have them linked with the National Standards.

The risk management framework was updated in line with recommendations from last year's inspection. There was a risk matrix in place which forms part of the risk assessment process with a tiered coloured system of green, amber and red. When a risk reached red, there was a cause for escalation which included consultation with Tusla social work departments and other professionals involved with the young people, where strategy meetings occurred to address the risks identified. The centre also had Pre-admission risk assessments (PARA), Collective Pre-admission risk assessments (CPARA), individual crisis management plans (ICMP), individual absence management plans (IAMP) and individual risk assessments as part of the overall organisational risk framework. Inspectors saw safety plans in place for young people that were drafted at care plan meetings or during strategy meetings, however observation logs as part of a safety plan, required review to show all visual checks of the young person in their flat, that were carried out by the day and night staff team. There was a centre risk register in place which identified several risks in the centre. These included risks presented by the young people as well as centre risks. The centre manager must ensure that risks identified for the centre are documented in the centre risk register and that risk behaviours of the young people are documented in the young people's risk assessments.

There was a management structure in place appropriate to the size and purpose of the centre and staff were aware of the structure during interview. The deputy manager stepped up when the centre manager was absent. There was a comprehensive delegation of tasks which outlined roles and responsibilities for staff members and for different in-house officers.

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 under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that the audits completed ensure compliance with the National Standards for Children's Residential Centres 2018 (HIQA).
- The centre manager must ensure that the audits identify where the gaps were in the service, actions addressing these and the person/people responsible for undertaking them.
- The director of service must include service improvement plans/goals for the centre in the annual report.
- The centre manager must ensure that the centre risk register holds the risks associated with the centre and not the young people's behaviours.

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 was undertaken by the centre manager and the deputy manager with oversight of the rosters, staffing, annual leave and training. There were appropriate numbers of staffing in the centre which was in line with the centres statement of purpose. Inspectors were informed that when extra staffing was required, this was facilitated by the team and relief staff.

The staffing list received as part of the inspection process contained a list of nine social care staff of whom three had a social care qualification, the social care manager and deputy manager were addition to this nine. The Tusla ACIMS memo 2020 on staffing identified that in order to be complaint with the relevant regulation staff teams along with having the appropriate quantity of staff must also have fifty percent of those staff social care qualified with the remainder in related and relevant areas. The centre staffing had not met the social care qualifications criteria at the time of this inspection.

There were three staff members that required a social care degree. One was completing a social care degree in college; one had agreed to commence the social care course in September 2022 and the third member had been offered support by the organisation and had registered to undertaking the course in February 2022. The

management within the organisation had offered support to these staff members to ensure compliance with requirements of the memo sent from Alternative Care and Inspection Monitoring Service in February 2020, however as noted earlier were in breach of this at the time of inspection.

Inspectors were informed there was a contingency plan in place in case of emergencies or with a covid outbreak. There were three relief staff available to the centre that covered annual leave and sick leave.

Mandatory training for staff was up to date with the only deficit in the practical element in the model of behaviour management. Inspectors were informed a staff member had now completed train the trainer course and all staff would receive the training shortly.

Inspectors reviewed a selection of personnel files and found one staff member had garda vetting in place however was missing a police check from another country. Management was looking for the police check as they had requested it and it had been identified as a deficit in an audit carried out.

Overall, there was a good level of staff retention in place within the organisation to ensure continuity of care and stability for the young people. Staff named the good support and guidance they received form line management and consistency as reasons they stayed or returned to work in the centre. The staff interviewed named the following arrangements in place which included competitive pay scales, group facilitation, counselling, training, support for education and EAP. The organisation had completed surveys with the young people, staff, family members and social workers to get feedback on where the organisation can make improvements.

On call procedures were in place in the centre between the centre manager and deputy manager covering evening and weekend support. The staff were aware of the on-call procedure and stated it was effective. The director of service was also available as second tier for on-call if needed.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider and centre manager must ensure that action is taken to ensure that the staffing qualifications comply with the relevant regulatory requirements without delay.
- The centre manager must ensure that all mandatory training was up to date.
- The centre manager must ensure that all vetting was up to date for all staff both nationally and internationally.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that the placement plans document details how the work was intended on being completed with the young people.	The centre is adapting the sister unit placement plan templates in January 2022 to ensure that the placement plans document details how the work was intended on being completed with the young people.	The centre is adapting the sister unit placement plan templates in January 2022 to ensure that the placement plans document details how the work was intended on being completed with the young people. This template will be used going forward.
5	The centre manager must ensure that the audits completed were in compliance with the National Standards for Children's Residential Centres 2018 (HIQA). The centre manager must ensure that	A new audit template is currently being devised by management. This tool will be aligned with the eight themes, identification of gaps, actions needed and person responsible to undertake them will be noted on the form. The next unit audit will be in April 2022 and this will be completed on the new audit tool *(see attached incomplete template)* The new audit template will include	New template that is in compliance with the National Standards for Children's Residential Centres 2018 (HIQA) to be used going forward. New template to be used going forward will

	the audits identify where the gaps were in the service, actions addressing these and the person/people responsible for undertaking them. The director of service must include service improvement plans/goals for the centre in the annual report. The centre manager must ensure that the centre risk register holds the risks associated with the centre and not the young people's behaviours.	identification of gaps, actions needed and person responsible to undertake them *(see attached incomplete template)* Next annual report is due in May 2022, service improvement plans/goals for the centre will be included in the annual report for 2022. The current risk register has been amended to ensure that the centre risk register holds the risks associated with the centre and not the young people's behaviours.	include identification of gaps, actions needed and person responsible to undertake them. Services improvement plans/goals for the centre to be included in all annual reports going forward. Centre manager to ensure that the centre risk register holds the risks associated with the centre and not the young people's behaviours going forward.
6	The registered provider and centre manager must ensure that action is taken to ensure that the staffing qualifications comply with the relevant regulatory requirements without delay.	One unqualified staff has since resigned effective 02.01.2022. One qualified staff who was on relief has been given permanent employment. An advertisement to be published on Active Link to recruit more staff with Social Care qualifications to ensure that the staffing qualifications comply with the relevant regulatory requirements without delay.	No unqualified staff will be offered employment in the centre going forward, to ensure that the staffing qualifications comply with the relevant regulatory requirements without delay.

	The centre manager must ensure that all mandatory training was up to date.	Rainbows now has an internal TCI trainer, qualified since November 2021, it is planned for staffing to complete the remainder of TCI in February 2022 to ensure that all mandatory training is up to date.	Covid restrictions are regulated by HSE. The centre will continue to do all training not affected by Covid restrictions to ensure that all mandatory training is up to date.
	The centre manager must ensure that all vetting was up to date for all staff both nationally and internationally.	All staff are nationally Garda cleared. One staff member has an outstanding police clearance from the USA. He has since been directed to apply for same clearance through the relevant embassy, to ensure that all vetting is up to date for all staff both nationally and internationally.	Going forward international police vetting to be completed before staff start employment in the centre to ensure that all vetting was up to date for all staff both nationally and internationally.