An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 083

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Rainbow Community Services Ltd**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Date of inspection:	**16th, 17th & 22nd November 2021**
Registration Status:	**Registered from the 19th of February 2020 to the 19th February 2023**
Inspection Team:	**Eileen Woods** **Lisa Tobin**
Date Report Issued:	**31st January 2022**

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 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 19th of February 2008. At the time of this inspection the centre was in its fifth registration and was in year two of the cycle. The centre was registered without attached conditions from 19th February 2020 to 19th February 2023.

The centre was registered to provide accommodation to five young people of both genders from age twelve to eighteen on admission. Their model of care was described as relationship based and trauma informed. Staff interactions were advised by additional positive behaviour support tools and aimed at bringing young people to a place of good self-management and self-awareness. 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
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, 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. This was a blended inspection with both onsite and offsite inspection activity.

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 20th of December 2021 and to the relevant social work departments on the 20th of 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 10th of January 2022, following a meeting on the 17th of January 2022 to clarify details within this CAPA an updated CAPA was provided by the centre management on the 25th of 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: 083 without attached conditions from the 19th of February 2020 to the 19th of February 2023 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.

Each of the four young people had a care plan on file at the centre. Two of the young people were on a yearly statutory review schedule and this was not proving adequate due to the nature of their social and emotional needs as well as preparation for leaving. The centre had identified the need for additional planning opportunities to both advance aftercare planning and to co-ordinate planning for their specific additional needs. Inspectors found that the centre and the two social work departments involved were organising to meet regularly to plan effectively during this time through strategy meetings.

The quality of the identification of actions across the care plans varied in quality and quantity. Of the two young people aged seventeen both had been referred to and assigned aftercare workers in accordance with the national policy on aftercare. Neither of these young people had a completed copy of an aftercare plan on file from their aftercare worker and these must be provided to inform good collaborative work. The centre manager and director of care stated that they had a process for following up on care plans, child in care review meetings, mandatory items for the files and aftercare plans. Inspectors saw some evidence of follow up at management level on outstanding items, this process of follow up at each level could be included in the existing policy.

The centre had a policy and procedure on care planning that within it addressed placement planning. Inspectors found that the centre's policies were not structured in line with the National Standards for Children's Residential Centres, 2018 (HIQA) and that the focus from the HIQA standards on child participation and quality assurance in order to drive improvements were not captured cohesively in the present policy document. The director of care confirmed to inspectors that another manager within the service was completing this work and it was planned to achieve this by early in 2022.

Inspectors found that the centre had a placement plan format in place that was utilised to create plans over a six-month timeframe with fortnightly updates at team meetings. The placement plans were created promptly upon admission and added to thereafter as the team's knowledge of the young people grew, they were also updated by the six monthly statutory child in care reviews where those occurred. Inspectors found some areas to address within the placement planning process, the format was being utilised retrospectively at times to note key work done more prominently than the forward planning for key work. At times key areas to address were lost during placement plan updates and this must be tracked more effectively. The governance reporting from the manager to the directors did not address key working and placement planning formally.

The young people each had two key workers, the second of whom they chose for themselves. The young people did not opt to meet individually with the inspectors but did complete questionnaires in which three out of the four young people said that their key worker discussed their placement plan with them. One of those three young people asked to see their placement plan following the question being asked on the inspection questionnaire. The key workers and centre management must review the way in which they case manage key working to ensure core goals do not drift and to increase rates of accountable key working across all four young people. They must look at their approach to consulting with, informing and involving young people in the planning process. There must also be focused quality assurance of key work and individual work as inspectors found examples of poor tone and reference to sanctions that required review and practice guidance from management. Inspectors also found that the staff team were clear and focused with their work on a daily basis, they knew what was expected and individually worked to deliver on continuity of care in a homelike environment with the group of four young people.

There was regular individual work completed by all staff and significant amounts of these were linked to placement plan and aftercare goals and the team utilised staff members areas of expertise or gender to ensure engagement on key areas of personal work with young people. Monthly reports were sent to social workers to update them on the work being completed. The social workers told inspectors that they were happy that the actions from the care plans were attended to and that communication was good. A social worker noted that the key workers were good even when changes in key workers assigned took place as it was a consistent core team who knew the young person well. The centre was described also by social workers as a stable long-term setting with routines and a positive approach.

Inspectors spoke with three family members who were very positive about the care provided and the staff team. They described good communication with and co-operation around planning and safe care for their family member. They were consulted with for care planning meetings and were aware that the centre staff created additional plans at the centre arising from agreements with social workers and families, these related to access, education, specialists supports and safety. A social worker communicated directly with the family for one young person and provided them with updates related to the young person's daily life. The staff kept good records of arrangements for family contact and communications regarding family wishes. There was evidence on file also of communication with social workers and other professionals involved with the young people. Friends were valued and promoted based on the available information.

All four young people gave feedback about the centre and their experiences there and all noted people there that they trusted and would speak to. They liked many aspects of their life at the centre including their activities and interests that they got to pursue. One young person described growing positively as something that had happened for them by living at this centre.

Each of the four young people had a range of different specialist requirements identified through their care and placements plans. The centre sourced different types of suitable counselling directly for the young people when required to avoid undue delays related to funding and other issues. There were specific plans put in place by staff members around complementary sensory work based on feedback from specialists and the social workers involved were aware of these plans. There were external clinical referrals and services in place and updated assessments had been commenced in some instances with outcomes pending to inform the work at the centre. One set of outcomes had yet to be shared from a partially completed assessment process and it was important that the social work department involved expedited the sharing of key information from this to the team. The centre had worked in a careful manner regarding the young people's mental health concerns with visits to GP's, support for referral to CAMHS and seeking services from Pieta House.

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 management and the director of care must review the case management for key working and placement planning to ensure that good planning and completion rates are observed.
- The centre management and director of care must review and implement a focused approach to consultation with young people with regard to their placement plans and overall planning at the centre.
- The director of care must implement a robust quality assurance and audit of key working and placement planning.

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.

The centre manager was part of an organisational structure that included a deputy manager at the centre and a director of care to whom they reported. There were also three social care leaders on the team. There were service level management meetings monthly and weekly governance reporting from the centre manager to the director. The content of both sets of reports focused on the care of young people and on the staffing of the centre.

There was a quality improvement plan in development by the director informed by the audit structure the director had introduced. The centre policies and their auditing were structured against the previous national standards. Inspectors found that the centre manager had completed a self-audit in March 2021 and this was followed by an audit by a senior staff from another centre in June of 2021. The audits as presently structured did not generate actions, timeframes and outcomes, in order to further support the centre's learning and development it is important that these audits be improved. Inspectors found that the audits completed in 2021 were not identifying issues in, for example key working linked to placement plan goals and appropriate use of sanctions. They did not critically examine decision making in a manner likely to cause further discussion and review. The centre management and director had decided to place temporary bars on the outside of a young person's ground floor window. This was identified by the centre as a restrictive practice but this was not in line with the centres restrictive practices policy and not in line with the purpose and function of this centre as an open residential centre. The centre manager stated that they spoke to the fire safety consultant and the social work department before this action. The placing of the bars was temporary but highlighted that in this instance better audit, risk management review and better policy integration with the national standards may have prompted a different type of accountability and decision making.

There was evidence of the centre manager and their deputy overseeing records through reading, signing and commenting on individual significant event reports. They held regular team meetings and attended handovers where team planning occurred.

The centre had agreed a contract with Tusla signed in 2021 for the provision of services over a four year period and they reported twice yearly to the relevant Tusla department in this regard. This requires that the reporting takes account of the relevant legislation but also the relevant national standards. The operational policies of the centre had been reviewed yearly and on an ad hoc basis to map in some new policies prompted by the HIQA standards into the existing format. The director must ensure that the policy document and the accompanying auditing system accurately represent the HIQA standards with a focus on responsiveness, accountability, rights and well being.

The centre had a risk assessment policy linked to behaviour management within the operational policies. They had a separate suite of health and safety documents including a safety statement. The deputy manager and the centre manager oversaw a

suitable risk register and reported to the director regarding the risks and their status. A matrix was utilised and the register was subject to quarterly or as needed review. The register addressed areas related to workforce, covid 19 and challenging behaviours. The monthly managers meetings did not have risk management or significant review as agenda items in the samples reviewed by inspectors, so it was not fully clear where risks related to young people and to the group were discussed and decisions made and implemented for safe care. What was clear was that staff knew the key areas of concern and when to respond as did the management and the director but the records and systems around it must be more co-ordinated to highlight actions in response and to track where areas of risk were settling down and why.

There were behaviour management plans and crisis response plans completed for young people. There were also some safety plans and preadmission collective risk assessments completed. There was evidence of two social work departments completing a consultation based on the mutual risks clearly identified by the centre management. The centre manager completed risk rating and comments following each significant event and there was evidence of some significant event review completed at team meetings. The significant events review or SERG process was recorded and could be more robustly utilised as a format overall.

Inspectors found that the staff were a consistent team who shared knowledge across handovers and team meetings but that the centre management must oversee that more robust reflection of safety planning related to low mood, group mix and self harm are put in place. And that where those risks become reduced or heightened that the plans reflect that change. The centre manager utilised their risk rating matrix on the significant event reports and outlined the heightened risks to the director in their governance report. This was not a formalised written escalation process.

The deputy manager provided cover for the centre managers annual leave and a range of staff had delegated duties. These were not captured in one document, and this should be put in place to capture roles and tasks.

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 director must ensure that the policy document and the accompanying auditing system updates to align with the National Standards for Children's Residential Centres 2018 (HIQA) is completed and implemented with delay.
- The director of care and the centre management must oversee more robust reflection of safety planning related to low mood, group mix and self harm.
- The director of care must co-ordinate the risk management procedures into a cohesive risk management framework that includes the centres risk escalation policy and procedure.
- The centre management must review the decision making with regard to restrictive practices and sanctions in order to inform practice and learning within the centre.

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.

The director of care held monthly manager meetings which included agenda items relevant to work force planning and team development. There was regular review of recruitment, the roster, working during the pandemic, the provision of breaks on duty and examination of any staff departures. The centre had a long established and experienced core team of eleven social care staff across ten posts, there was also a

deputy manager and a centre manager in post. There had been three changes to the staff team since the November 2020 inspection and of those one moved through promotion to the company's other centre. The managers meeting evidenced review of the staff departures, the young people's comments or concerns about team changes and in response the director and CEO implemented recruitment and retention strategies designed to protect the stability of core service delivery. These included pay increases and staff benefits such as financial support for study and staff support sessions with an external facilitator.

The staff team consisted of a balance of six social care qualified staff members with the others qualified in a relevant equivalent area. There were three social care leaders with one of the three falling six months under the recommended three years post qualifying experience for this level of role. The centre and director had a plan in place to take account of this and to oversee the transition into the role through the induction and probation systems.

Inspectors found that the staff team were on balance experienced and demonstrated an ongoing proactive and positive approach, with lots of activity and connection with the young people. The roster was structured to have three staff available related to travel for family access and other busy times for the young people. One staff member worked forty-eight hour shifts due to their distance from the centres location and they completed aspects of the eco therapy programme in place. The centre management had completed a risk assessment for this working pattern and stated that it was kept under review. Inspectors found that on occasion other staff had completed double shifts but these were rare and in response to sick leave and pandemic impacts. Staff stated to inspectors that this was not a regular or expected practice and that their balance of working time and time off was well planned for and respected.

Inspectors were told by team members about the positive impact of the staff retention and support changes and added that there was a good staff wellbeing service available to them through which they could access external counselling and support as well as other schemes like the bike to work scheme.

The centre had an on call service provided by the centre manager and the deputy manager, the person on call was listed at the top of each roster. The director of care provided senior on call back up to the centre in the event of an emergency. The centre did not have a procedure for the provision of on call and may wish to consider formalising this.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

None identified

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre management and the director of care must review the case management for key working and placement planning to ensure that good planning and completion rates are observed.	There is a key-working and placement planning process in place, Management acknowledge that the completing and understanding of the placement plans by new key-workers has been a challenge. A leaders meeting has been scheduled for 26/01/2022 to shed more light and training into the placement plan template. The leaders will then be delegated to train and shadow current key-workers in the placement planning process	Ongoing oversight by management regarding the implementation of placement plans on a monthly basis following leaders meeting
	The centre management and director of care must review and implement a focused approach to consultation with young people with regard to their placement plans and overall planning at the centre.	It has always been a commitment of the service to include the young person's voice as an important element of the individual and service plans. The management will review the young person's consultation process to ensure it is meeting the current needs and being evidenced in the service planning systems. The young people will	The management will review the young person's consultation process to ensure it is meeting the current needs and being evidenced in the service planning systems. Evidence of the young person being offered the opportunity to read and sign their placement plans on a regular basis will be recorded.

		continue to be offered formal and informal opportunities to make their voice heard.	
	The director of care must implement a robust quality assurance and audit of key working and placement planning.	There is currently a process of audits in place as required by the national standards. Moving forward the director will be emailed the placement plans in addition to the monthly reports to give reassurance that they align with the care plan.	The director will be emailed the placement plans in addition to the monthly reports to give reassurance that they align with the care plan.
5	The director must ensure that the policy document and the accompanying auditing system updates to align with the National Standards for Children's Residential Centres 2018 (HIQA) is completed and implemented without delay.	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 process of internal and cross service audit will continue to be implemented with the combination of annual, bi-annual and cross service audits meaning that is an audit element occurring minimally quarterly.	New template that is in compliance with the National Standards for Children's Residential Centres 2018 (HIQA) to be used going forward. Each audit identifies actions, timeframes and responsible persons.
	The director of care and the centre management must oversee more robust	The management and leaders will undertake a review of the risk	The management and leaders will undertake a review of the risk management

	reflection of safety planning related to low mood, group mix and self harm.	management process to ensure there is a co-ordinated approach which allows all staff to be able to implement risk management strategies in place. This will have a particular emphasis on issues relating to low mood, group mix and self-harm ensuring there is a comprehensive risk evaluation and strategy to accommodate these issues should they arise. To be completed by 31/03/2022	process to ensure there is a co-ordinated approach which allows all staff to be able to implement risk management strategies in place.
	The director of care must co-ordinate the risk management procedures into a cohesive risk management framework that includes the centres risk escalation policy and procedure. The centre management must review the decision making with regard to restrictive practices and sanctions in order to inform practice and learning within the centre.	The Director of Services has completed a review of the risk management policy and framework including a detailed outline of the risk escalation process that is currently in place. Management will address the issue of restrictive practices and sanctions at the next team meeting 16/02/2022 and in particular address learning from a particular incident in Feb 2021.	The Director of Services has completed a review of the risk management policy and framework including a detailed outline of the risk escalation process that is currently in place. The management will review the sanctions and restrictive practices and co-ordinate with the SCL's an update of the decision making process around these so as to provide consistency for the team and young people.
6	None identified		