An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 107

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Pathways Ireland Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**23rd & 24th of August 2021**
Registration Status:	**Registered from the 30th of November 2021 to the 30th of November 2024**
Inspection Team:	**Eileen Woods** **Cora Kelly**
Date Report Issued:	**6th October 2021**

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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 30th November 2015. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from the 30th November 2018 to the 30th November 2021.

The centre was registered to provide medium to long term care for up to four children of both genders between the ages of thirteen and seventeen years on admission. In exceptional cases the centre takes children outside of this age group under derogation. In line with this process, one child under thirteen years was residing in the centre. The centres statement of purpose and function described the model of care as client centred and needs led involving collaboration with children, their families and professionals, in a homely and nurturing environment. There were three young people living there 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 Only
5: Leadership, Governance and Management	5.2 Only
6: Responsive Workforce	6.1 Only

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 13th of September 2021 and to the relevant social work departments on the 13th of September 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 16th of September 2021. 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: 107 without attached conditions from the 30th of November 2021 to the 30th of November 2024 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 three young people in the centre had a care plan created for their placement, the young person admitted since the previous alternative care inspection and monitoring service 2020 inspection had a care plan meeting held shortly after admission in line with social work care planning guidelines. Due to the cyber attack and other staffing factors Tusla social workers could not provide official copies of the care plans and child in care review records in the time frames they would have wanted. These copies have since been restored in most instances. Child in care reviews were held in accordance with the national protocols for those under and over the age of thirteen.

The centre management had organised for meetings to be held to discuss the actions as identified in the care plans and one of the young people had monthly child in care reviews which continued uninterrupted through the pandemic and the cyber attack phase. The centre manager or the deputy manager along with a social care leader or the key worker attended all statutory and supplementary planning meetings for young people and there were clear, good quality centre minutes maintained of these. The social workers were happy with the structure and content of all meetings held and stated that the centres records were accurate and in line with their expectations for the placements.

There were placement plans on file for each young person and there was a policy on placement planning available. Inspectors found that the goals contained within the placement plans were in line with the care plans. The centre format expanded beyond that appropriately into the holistic needs of each young person. The plans were prepared by the young persons allocated key worker supported by a social care leader, thereafter, they were discussed at the team meetings. The plans had weekly and monthly goals extracted for action by key work sessions or individual work by the team members. The centre policy was non specific on time frames for placement plan cycles and their case management structure and inspectors recommend that that be considered at the next policy review.

The placement plans themselves were lengthy as they ran in review schedules that varied from three to six month cycles, with one plan measuring over 140 pages in length. Inspectors found that the placement plans contained all the actions and sessions completed to support the goals and that gaining the voice of the child was structured into the plans. The staff knew the placement plans objectives through their weekly team meetings and the extracted key working plans, these were further supported through daily handover plans. The social workers were familiar with the content of the placement plans and had reviewed records related to the direct work on their regular visits to the centre. Each of the three young people had an allocated social worker who visited frequently and in excess of the guidelines for social work visits. The social workers described the centre as homely and the staff team as skilled and consistent in caring for the young people, they identified positive ongoing outcomes they had seen in their young person's quality of life.

The young people were linked to a range of specialist services relevant to their needs, these included therapeutic, clinical and medical support services. Where there were newly identified specialist needs a referral had been made by the social workers. There was robust evidence of the centre manager advocating for the young people's specialist needs. There was evidence of a well organised and committed staff team who understood and acted on the advice and direction of the specialists. There were a number of areas of important detail to follow from a range of specialists and the staff team kept clear records of these and implemented the required interventions and supports. The role of the team as per each aspect of the various specialists advisories was well laid out and integrated into the young people's plans.

The centre staff team and management had regular structured communication with the social workers, these included monthly child in care reviews, visits, emails, calls, meetings. The inspectors evidenced this from their review of the relevant written records. Inspectors were greeted by all three young people at the centre and met with one young person by their request. They talked about being happy with living at the centre and they had questions relating to their care that were social work led decisions. The inspectors spoke with the relevant social worker who was already familiar with the questions and requests and they had, along with the Guardian Ad Litem, acted to address these matters. They were due to meet the young person shortly after to discuss these and the actions taken.

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

Compliance with standards	
Practices met the required standard	**Standard 2.2**
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**

Regulation 5: Care Practice s 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.

This centre had maintained the same centre manager in post for the past three years, this person was experienced and provided an ongoing standard of evidenced leadership around the care of the young people at the centre. There was evidence of a team approach and cohesion with clarity at all levels within the centre about roles, responsibilities, and goals for the young people. The centre manager worked with an acting deputy manager to provide management presence Monday to Friday, there were also three social care leaders in post. The deputy manager was appointed to the post to cover a period of specified leave for the previous deputy manager, and this will remain ongoing for further months.

The centre manager and their deputy organised the delegation of tasks and named roles and tasks were assigned to the deputy and to the three social care leaders. Records were maintained of these and of any preparations for alternative management arrangements to cover annual leave. There was monthly reporting from the centre management to the senior managers meeting and managers meetings, records maintained of the managers meetings detailed effective discussion of young people's needs and follow through on agreed actions. The centre manager reported to the service manager. There were monthly thematic internal audits completed

which were overseen by the company compliance officer and onsite quarterly audits by the service manager. There was evidence of actions generated and responded to within a structured timeframe and the systems supported ongoing learning, development and accountability at the centre. The service manager had visited the centre regularly and had met the young people as part of that. They observed that the young people were settled and doing well a view echoed by all three allocated social workers.

The company had an organisational structure with persons at each level internally and externally in post to support the centres governance and development. There were key persons in HR, training, development, therapeutic advice and leadership. The director of services convened a policy group that created a new set of policies during early 2021, these were created in line with the National Standards for Children's Residential Centres HIQA (2018), relevant legislation, national guidelines and regulatory requirements. A process of consultation took place across the staff teams and managers led by the senior management team. The policies were deemed to be completed although the organisation maintained them as live and stamped draft until the full roll out of all policy training had been completed in September 2021. Thereafter they plan to review them, incorporate any feedback and finalise the policies. Individual thematic groupings of policies had been circulated through the team meeting forum, through supervision and had been available to staff to read and review.

The director outlined that service provision agreements had been signed with Tusla for the next four years and that they continue to provide the evidence to the relevant department within Tusla of their compliance with their contractual commitments.

The centre utilised the 2021 updated risk management policy provided by the organisation. This policy, inclusive of the supporting risk rating matrix and risk register, had been revised after alternative care inspection and monitoring service inspection direction and feedback in 2021. Inspectors found that a training module had been developed by the organisation and this was booked for staff to complete during the first two weeks in September. There was a well presented risk register in place that had been updated on a monthly basis, the register and its risks were reviewed by the centre manager who held lead responsibility for risk management within the centre. Externally, the director of service led the risk register review for this and other centres within the organisation at the senior management meetings.

Inspectors found that the staff had a core understanding of risk management, they utilised risk assessment forms for a variety of individualised risks arising, some related to health and safety, for example use of a scooter and others related to, for example, mood issues. There was good quality individual crisis support plans and behaviour support plans on file underpinned by young person profiles and some of these aforementioned individual risk assessments. The behaviour plans were updated after significant changes or monthly as required. The staff had good knowledge of the current risks for young people with the three social workers noting that safety and safe care was well organised and delivered at the centre. There had therefore been changes in how risk was assessed and tracked in policy, but inspectors found that the process from initial risk assessment on file for a young person and how this informed or not other plans and how it might become a matter to be escalated to the risk register was still an aspect of practice that the team were unclear about. Records forwarded to inspectors following the onsite inspection demonstrated discussion of risk at team meetings but did not clarify how these individual risk assessments fit into the wider framework. Inspectors recommend as part of the ongoing roll out of practice in risk management that it is clarified with the team what the risk assessment form is for, how often it should be reviewed and how they can be closed once addressed successfully, updated if still required or escalated further to ensure appropriate action. Inspectors also identified that an updated medical opinion would be required as soon as possible for the crisis management plan for one young person regarding the use of restraint.

The centre manager implemented pandemic control measures at the centre through infection control and hygiene routines. Risk assessments were implemented for all visitors to the centre.

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

Compliance with standards	
Practices met the required standard	**Standard 5.2**
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**

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 centre had a suite of policies in place that related to staffing, these included policies on recruitment and workforce planning. The centre manager had a number of avenues through which they addressed work force planning. Within the centre this involved managing the roster to plan for all types of leave and for any study needs on the team. The centre manager shared the roster planning responsibility with the deputy social care manager. The centre manager reported externally to their service manager on the numbers of staff in post, any gaps that were upcoming or recruitment needs that may have arisen. All staffing needs were then discussed and recorded for action at the monthly managers meetings. There was also a system in place for unexpected gaps on the roster through the on-call system and a process for the management of Covid -19 should same be required.

Inspectors found that the centre had the staffing cohort identified in their application for registration with the alternative care inspection and monitoring service and in their statement of purpose and function of a social care manager, a deputy social care manager, three social care leaders and five social care workers, there were also four relief staff listed. The staff team were qualified with the relevant or related qualifications for their posts and there was a balance of experienced to new staff with a low rate of change on the team since the last alternative care inspection and monitoring inspection in August 2020. Inspectors reviewed the daily logs and rosters along with specific risk assessments and management plans for the young people and found that the staffing levels did not meet the daily triple cover level that the centre determined was needed to meet the needs of the group of three young people. The daily logs and the rosters did not present as consistently recording where triple cover was present also, the centre management must ensure that they identify and log all staff present on daily logs and ensure to have the required third person cover.

Three sample personnel files were reviewed, and inspectors found that were items that required action for one file and have requested that these be done to bring the personnel file up to standard. There were measures in place to support staff

retention, some of these were also captured in a staff support and retention policy. There were practice based supports at the centre, an employee assistance programme and additional employment benefits for staff. The young people at the centre presented as settled overall and engaged with their key workers, the social workers reported that they found a sound relationship-based approach in place. The social workers added that there was a consistent well-informed staff team at the centre from the centre manager down and that they were welcomed when they visited the centre. They had access to the young people's files to review, that contact with the centre was of a high standard and that they had positive feedback overall from their young person, the families and other professionals.

The centre had an on-call policy in place and records were maintained of the calls made by both the person on call and the persons making the calls. Additionally, the calls were logged to the online system and an alert issued to the senior management team. Prior to the implementation to the organisations Covid- 19 contingency plans the on-call system was companywide, this had become centre based only as a response to managing locally. The policy reflects the pre pandemic procedures and the senior management and policy team should review this aspect in their next policy review.

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

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

Actions required

- The centre management must ensure that they identify and log all staff present on duty with young people on the daily logs, those present in all roles on the rosters and ensure that they maintain the required third person cover.
- The service director must ensure that the personnel files contain the required vetting and a QQI verification of a relevant qualification in the identified instance.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	None identified		
5	None identified		
6	The centre management must ensure that they identify and log all staff present on duty with young people on the daily logs, those present in all roles on the rosters and ensure that they maintain the required third person cover. The service director must ensure that the personnel files contain the required vetting and a QQI verification of a relevant qualification in the identified instance.	The centre manager will ensure going forward that all staff on duty are recorded on the young person's daily logs and all staff and management present are recorded on rosters. A new rolling roster is being implemented in the centre on 1/10/2021 to ensure that third person cover is maintained by centre as required. The service director will ensure that the care team member's personnel file contains the required vetting and QQI verification of a relevant qualification as identified. This action will be completed by	The centre management team will overview daily logs daily to ensure that all staff are recorded accordingly. Rosters will be reviewed by centre management on a weekly basis to ensure that all staff and management present are recorded on same. A new rolling roster is being implemented in the centre on 1st October 2021 to ensure that third person cover is maintained by centre as required. A new auditing system of staff personnel files was implemented by the service in September 2021. The centre management, in conjunction with the HR department, will conduct quarterly audits of staff

		01/10/2021.	personnel files to ensure that they contain all required documentation. The compliance and complaints officer will also inspect the personnel files when conducting audits under theme 6 of Pathways Irelands internal audit system.