An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 115

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Gateway Residential Care**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Unannounced themed inspection**
Date of inspection:	**2nd and 3rd October 2023**
Registration Status:	**Registered from 17th June to 2022 to 17th June 2025**
Inspection Team:	**Linda McGuinness** **Lorna Wogan**
Date Report Issued:	**1st December 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 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 17th June 2016. At the time of this inspection the centre was in its third registration and was in year two of the cycle. The centre was registered without attached conditions from the 17th June 2022 to the 17th June 2025.

The centre was registered as a multi-occupancy centre to provide medium to long term care for two young people from age thirteen to seventeen years on admission. The centre aimed to help young people recover from adverse life experiences. The model of care was built on a strengths-based approach. The approach to working with children was informed by both attachment and resilience theories. The approach was also trauma informed and staff received training to understand the impact of trauma on child development. The staff team aimed to increase protective factors and promote resilience by providing a safe environment, access to positive role models, opportunities to learn and develop skills and to build a sense of attachment and belonging. There were two 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.

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 person, 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 23rd October 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 6th of November 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: 115 without attached conditions from the 17th June 2022 to the 17th June 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

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.

Overall inspectors found that the centre was proactive in planning and providing supports to young people living in the centre. While each young person had a care plan on file the centre was waiting for an updated plan for one young person following their most recent child in care review. There was evidence that young people were encouraged to participate in care planning and one young person attended all their statutory review meetings. If young people chose not to attend, efforts were made to ascertain their views, their key worker advocated for them at the meeting and provided feedback on discussions and decisions. Detailed weekly reports and monthly progress reports were sent to social workers that set out key areas of need and development and facilitated effective planning. Where possible, parents were given opportunities to attend and contribute their views.

Inspectors observed warm caring interactions between one young person and staff members during their visit to the centre. This young person met with inspectors and confirmed they were involved in daily and weekly planning and attended their planning meetings. They spoke of feeling safe and happy in the centre. They were engaged in fulltime education and involved in activities within the community. The other young person chose not to meet with inspectors but they provided written feedback that was generally positive.

There was evidence that each young person had opportunities to input to placement planning and set their own goals. They were also afforded opportunities to feedback on the care being provided in the centre. Each young person had an up-to-date placement plan based on their care plan. Inspectors found these were detailed and covered specified areas of need and established tangible goals for the team to work towards. Inspectors found evidence of key working aligned to the goals of care plans and placement plans.

In the case of one young person who often declined to engage in the planning process, inspectors found that the attachment specialist had informed the centre in April 2023 that-further specialist supports should be explored. This was to be brought to the upcoming child in care review and the organisation had begun to explore other options. The inspectors found that the care plan for one young required a clearer action plan to assess, monitor and respond to their specific needs as they prepare them for leaving care.

There was a structure was in place to ensure that placement plans were reviewed and they were overseen by the centre manager and the regional manager. The placement plans were updated every three months or as required. Inspectors found that while placement plans were discussed, updates to specific areas of the plans were not signposted in the minutes of team meetings and this is recommended. An individual work schedule was developed each month that guided individual work and key working. Inspectors founds this work evident on young people's files. A monthly progress report was completed based on goals of placement plan and the outcomes the planned work.

The individual crisis support plans (ICSPs) and absence management plans (AMPs) for each young person were reviewed on a monthly basis and were forwarded to social workers for approval. Inspectors found that contraindications to restraint were not included on an ICSP and the young person's permitted time outside the centre was not on the AMPs as required. The centre manager indicated these would be updated immediately following inspection. There was evidence that social workers were afforded opportunities to provide feedback on the care being provided and this was reviewed by management.

Planning for young people was based on the model of care and supported by an attachment specialist and a consultant clinical psychologist. Inspectors found that one young person in particular had made significant progress since moving to the centre and the supervising social worker complimented the work undertaken by the team to support the placement goals and reducing risk. There was evidence that the young person had developed trusting relationships with staff and this had contributed to positive outcomes for the young person to date.

There was effective delegation of key working and individual work to all staff and those interviewed were clear about their responsibilities to work towards identified goals. The social worker of the second young person spoke highly of the commitment of the team to the young person and how they had developed good independent living

skills. The social worker stated that the team were well supported by management to manage difficult behaviours and situations.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 17**
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**

Actions required:

- None identified.

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.

Overall, inspectors found that there were robust governance systems in place that promoted a culture of safe and effective care. However, clarity was required in terms of the organisational structure and the organisational map must be updated to include additional roles within the management structure.

There were recent changes within the internal and external management structure. The acting centre manager was in post for four weeks at the time of inspection following the transfer of the centre manager internally. This staff member previously held the deputy manager post in the centre, and this provided a level of consistency for both staff and young people.

They reported to a director of operations who had external line manager responsibility for two centres in the organisation. A regional director held responsibility for the other four centres. As previously stated, the organisational map must be updated to include new and additional posts to provide clarity in relation to the external line management structure.

A review of the governance systems and completed compliance audits evidenced robust systems in place, incorporating quality assurance, finance and human resources departments. There were regular compliance audits, management meetings, senior management meetings, monthly governance reports that were submitted to line managers. Governance reports were subject to a monthly quality assurance process by the director of operations. All required actions arising from audits fed into a comprehensive quality improvement plan that was monitored and checked for progress and sign off.

The acting centre manager was supported by an acting deputy manager and there was evidence that the director of operations provided more regular check in and supports due to the recent changes of management in the centre. Senior managers were provided with a daily update that outlined key information in relation to risks or significant events in the centre. There was a system for delegation of management tasks however this was not in operation at the time of inspection and should be reinstated by the newly appointed acting centre manager.

Inspectors found that the acting manager worked office hours Monday to Friday, and provided good support to the team and was focused on the provision of child-centred care. There was evidence that they held staff members to account in supervision. They completed and submitted governance reports on a monthly basis that included planning for young people, significant events, complaints, staffing, supervision and child protection concerns. The social care leader interviewed was clear on their role and responsibilities. Other staff who spoke with inspectors reported that the manager was supportive and encouraged reflection on their work.

The Chief Executive Officer (CEO)confirmed that a service-level agreement was in place with TUSLA, the Child and Family Agency and that they met regularly and provided updates to the national private placement team as required.

The organisation had a suite of policies and that was regularly reviewed and communicated to staff teams. There was evidence of regular discussions around

specific policies at team meetings to ensure that all team members understood and implemented the policies in practice.

The inspectors found that information about the young people was shared appropriately with relevant people, policies and procedures were updated when required and there was evidence of workforce planning. A three-year strategic plan was in development at the time of inspection and the CEO expected this to be completed and disseminated by year end.

Inspectors reviewed a sample of personnel files and found that several did not contain all the required documentation for example mandatory training certificates, evidence of induction and job descriptions. The inspectors found there was a good emphasis on training within the service however the staff training database was not up to date for all staff.

Senior management must conduct a review of personnel files and address any deficits. Review and oversight of personnel files should form part of regular oversight and auditing of the centre.

There was a risk management policy dated May 2023. All staff interviewed were familiar with the risk management framework that utilised a likelihood/impact matrix. The associated risk registers were maintained and regularly monitored however, the outcomes of discussions relating to risk assessments and updates to risk management/safety plans should signposted in the team meeting records.

Compliance with regulations	
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 updates to risk assessments and risk management plans are signposted on the records of team meetings.

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.

There was evidence of regular workforce planning both by the centre managers and by the external line manager for the service. There was a human resources department dedicated to recruitment and retention. Workforce planning was a standing item at managers meetings. The acting centre manager also produced monthly governance reports that were provided to senior managers in the organisation and these set out staffing requirements.

Inspectors found that there were significant staff changes in the centre. Twelve staff members had left since the last inspection of this service. Two were promoted within the organisation, three were transferred to other centres and two left to travel, with the remainder tendering their resignations for personal reasons. At the time of inspection, the centre had a staffing complement of an acting centre manager, acting deputy manager, one social care leader and six social care workers. The acting deputy manager was not specifically assigned a nine to five role and worked the roster alongside the staff team. Three core team members have remained since 2021. There was a balance of experienced and more recently qualified staff who were being supported to develop the skills to meet the needs of the young people.

Management was aware of the impact of the work on staff and of the potential risk of vicarious trauma and supports for staff were built in through supervision, debriefing, the availability of the clinical psychologist and an employee assistance programme (EAP). However, while these supports were welcome and acknowledged by the staff team inspectors found that some staffing practices in the centre were not congruent with this approach as staff worked extra shifts and long hours in the centre.

The roster pattern in place at the time of inspection saw two staff cover overnight shifts and there was also a day shift in place to facilitate implementation of a risk

management plan requiring 2:1 cover. The centre had access to a panel of four relief staff however some were covering full lines on the rota due to the need for 2:1 cover at the time of inspection reducing their availability to cover unplanned leave. There was not a reliance on other centres to provide cover however staff members sometimes covered extra shifts to fulfil the required roster. Inspectors found from a sample review of rotas over 12 weeks that there was significant incidence of staff covering back-to-back shifts and completing two overnights (48 hours) or a long day shift following an overnight (35 hours). nOn two occasions during this period staff remained in the centre for 62 hours. Taking into account complex needs of young people this is not in line with the planned rota or best practice and must cease.
The regional manager must conduct a review to determine if the centre has adequate numbers of social care workers to meet the needs of young people and agreed rota of two sleep overs and one long day shift and to also have sufficient cover for emergencies and other types of leave.

Inspectors found that was no evident process in place to undertake a risk assessment when a disclosure was made on a Garda vetting documentation.

There was a policy relating to staff retention dated 2022, there was specific roles on the executive team related to workforce planning and the CEO indicated that recruitment and retention formed a significant part of the three-year strategic plan that was imminent. There were some arrangements in place to promote staff retention. There was a consultation with staff members about retention ideas, some actions were implemented at the time of the inspection for example a staff bonding day, wellness checks, an EAP and salary increases. From a review of records, exit interviews and inspection interviews it was evident that salaries remained an issue at the time of inspection.

There was a process in place whereby exit interviews were conducted by a senior administrator external to the centre and forwarded to HR managers for analysis and review. However, the inspectors found that centre managers did not get feedback from exit interviews undertaken by staff who left their team. The registered proprietor must ensure that centre managers get feedback from exit interviews to promote reflection and implementation of proactive measures in respect of staff retention.

Additionally, inspectors found that there was no protected time for handover that was built into the working day and the situation at the time of inspection required that staff come on shift early and leave late. As part of effective planning there must

be protected time for a handover meeting that is not dependent on goodwill. Inspectors reviewed a record during early 2023 where a decision was made to pay staff for handover however this was not yet implemented at the time of inspection in October 2023.

Inspectors found that there was an on-call policy in place and there were suitable procedures for on-call arrangements at evenings and weekends. Staff confirmed in interview that they knew in advance who was on call and that the on-call service was reliable and responsive.

Overall, whilst the inspectors acknowledge that, to date, the needs young people have not been significantly impacted as a result of staffing challenges, the registered provider must ensure that the workforce is organised and managed to deliver ongoing child-centred safe and effective care and support. Robust recruitment and retention measure must remain a priority.

Compliance with regulations	
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 registered provider must ensure the practice of staff working back-to-back ceases.
- The registered provider must ensure that there is protected time allocated to the handover meeting.
- The centre manager must ensure when there is a disclosure on a Garda/Police vetting that a risk assessment is completed and held on the personnel record.

4. Corrective Actions and Preventive Actions (CAPA)

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again with time scales
2	None identified.		
5	The centre manager must ensure that updates to risk assessments and risk management plans are signposted on the records of team meetings.	1st of November onwards the centre manager to ensure all risk assessments and risk assessment updates are clearly stated within team meeting minutes.	Risk assessments to be added to as a standing item on team meeting agenda to ensure they are not overlooked. Centre manager to use oversight and reject any minutes from team meeting minutes that do not reflect risk assessments and updates to ensure these are included before minutes are circulated. This will be reviewed as part of the centre's internal audit process.
6	The registered provider must ensure the practice of staff working back-to-back ceases.	This practice has ceased. The centre manager will maintain oversight of the rota to ensure this does not re-occur.	Internal recruitment specialists are focused on recruiting relief staff to cover annual leave and sickness.

	The registered provider must ensure that there is protected time allocated to the handover meeting.	The registered provider has scheduled a meeting with directors on the 14.11.23 to discuss handover and to ensure there is a protected time allocated to this going forward. The development of this process will be communicated to management as part of the management meeting scheduled on the 20/11/23, management will then communicate this to staff teams.	Rotas and hours are reviewed monthly by the director of operations. The development of this process will be communicated to management and staff and will be overseen by the centre manager and director of operations.
	The centre manager must ensure when there is a disclosure on a Garda/Police vetting that a risk assessment is completed and held on the personnel record.	Senior administrator will notify centre manager of any disclosures arising on Garda vetting/police checks during the vetting process. Centre manager will ensure any disclosures noted on Garda or police checks on any current staffs or new staff are risk assessed and stored within personnel file. Commenced October 2023.	This will be monitored as part of the centre's internal audit process.