An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 130

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**24hrs Care Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**16th & 17th November 2022**
Registration Status:	**Registered from 14th August 2020 to 14th August 2023**
Inspection Team:	**Lisa Tobin** **Catherine Hanly**
Date Report Issued:	**1st February 2023**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 14th August 2017. 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 14th August 2020 to 14th August 2023.

The centre was registered as a multi-occupancy service. The centre's purpose was to provide accommodation for four young people of all genders from age thirteen to seventeen years on admission. The centre's model of care was trauma informed care which enabled young people to participate to their full potential in environments, carefully planned to serve individual needs. It aimed to promote positive outcomes through education and building positive family connections. 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
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.2
4: Health, Wellbeing and Development	4.2

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 22nd December 2022. 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 January 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: 130 without attached conditions from the 14th August 2020 to the 14th August 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

Inspectors found evidence of how young people's voices were captured throughout the file review completed. This included their involvement and participation in their Child in care reviews (CICRs), attending young people's meetings, through key working and individual work and having their voices recorded in their daily logs.

During interviews, inspectors were informed that staff used their relationship and built trust through engagement in activities to create a culture of openness and transparency in the centre. This occurred from the outset, during the pre-admission process where young people were given young people's booklets which informed them of their rights and expectations in the centre.

There was a policy on the complaints system in place which was reviewed and updated in June 2022 following recommendations from previous inspections within the organisation earlier this year. A new child-friendly complaints form for young people and a new form for staff to complete was introduced following the review of the complaints policy. The policy named the centre manager as the complaints officer which staff were aware of. Inspectors received a mixed response from staff regarding their knowledge of the complaint's procedure. It was not evident to inspectors what the processes were for complaints as this was not clearly identified by the staff when interviewed.

Inspectors saw one complaint made by staff on behalf of a young person that was due to be admitted to the centre, that did not follow the procedures that were outlined in the organisation's complaints policy relating to the current care the young person was receiving. Inspectors saw that this issue was escalated to senior management and further action was taken in contacting senior members within Tusla social work department and notifying the Alternative Care Inspection and Monitoring Service (ACIMS).

Inspectors noted on both young person's daily logs where they had complained or asked for a complaints form, however the complaints box was not ticked and no follow up was identified in the young person's daily logs. Inspectors saw in the centre's policy that if a young person does not wish to write up the complaint, a staff member must still type up the form in the young person's own words. Inspectors did not see this for both these instances. The procedures in the complaints policy must be reviewed with the team to ensure they understand the processes in place.

The new complaints documents had not yet been used in the centre as there had been no complaints since July 2022. Inspectors reviewed the complaints in the young people's file and noted there was a lack of information around the outcome and feedback section as it was unclear from the form if the complaint was closed, as there was no date identified or if any follow up was required. Regarding a complaint in July 2022, it was noted by inspectors through the file review that the young person was happy the complaint had been made and their voice was heard however the feedback did not include how the young person actually felt about the outcome of their initial complaint. This information was captured better in the complaints register but must also be available in the complaints form.

The young people were made aware of the complaint's procedures during the admission process, at young people's meetings, in the young person's booklet and in general discussions when addressing a concern of their right to make a complaint. On reviewing the young person's booklet, inspectors noted that it identified the external services available to the young people should they wish to utilise them however it didn't detail how internal complaints were processed or by whom and didn't give timelines for said processes. Inspectors saw that the complaints procedure was explained to the young people during admission. The above information must be added to the booklet to give clear guidance around the processes to the young people.

Staff in the centre were aware of their role in supporting the young people to access the complaints process. The young people were supplied with information about Empowering young people in care (EPIC), the Ombudsman for Children (OCO) and their social workers details should they wish to contact them about any concern.

The complaints register recorded the details of the complaints made by the young people. There were 8 complaints on the register provided to the inspectors since February 2022, all of which were clearly recorded as closed. The register gave a better insight to the status of the complaints in comparison to the individual

complaints forms themselves, which were unclear if they were opened or closed. The register was detailed with the relevant information regarding if the complaint was managed internally or externally and if the social worker and guardians were informed. However, the last complaint recorded did not have all the most recent updates recorded.

As part of the complaints form, the centre had included a section at the end which identified the possible root cause of the complaint raised. This was linked to a date where the complaint had been discussed at a team meeting for the purpose of learning and review. Inspectors saw that complaints were part of the agenda for team meetings and for senior management meetings and were discussed when any were identified.

Inspectors reviewed an audit that had been completed by the director of compliance and the regional manager on 1.6 of the National Standards in July 2022. This gave an account of where evidence of work was completed with the young people and had actions attached to improve the processes in place. Inspectors noted that one area of making a complaint on behalf of a young person was to be explored by the team and following this, staff made a complaint on behalf of the young person. It was uncertain to inspectors how or if the audit included interview or meeting with staff to gain their knowledge on the complaints process. Inspectors found that staff did not have a good working understanding of the policy and its implementation.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None identified**

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

Actions required

- The centre manager must review the complaints processes with the staff team to ensure they understand the procedures involved and that all staff follow it.

- The centre manager must ensure that the complaint forms state the outcome of the complaint, the most up to date information of what has been completed and the feedback from the young person on how they felt about the response they received. This information must also be reflected in the complaints register.
- The centre manager must ensure that all relevant details are included in the young people's booklet regarding the complaint's procedures.

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

Theme 3: Safe Care and Support

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

Inspectors reviewed policies relating to behaviour management and challenging behaviours. This outlined how the team focused on the root cause of behaviours for the young people and address them accordingly through utilising their training in their model of behaviour management, using the approaches outlined in the individual crisis support plans (ICSPs), using the guidance of the care approach documentation and the oversight of responding to concerns as they arose through risk assessments. From reviewing the training log, inspectors saw that all staff members had received training in a model of behaviour management and the model of care training was undertaken during the induction process. Inspectors were informed during interview that some staff required supports to improve their practical skills due to the level of their experience. Inspectors found that during interviews with some staff, they lacked the knowledge of the guiding policies, procedures and practices undertaken around the management of behaviour in the centre. Inspectors were informed of on-going supports required for staff in developing and guiding them in building relationships with the young people. The centre manager informed inspectors of their intention to work on the floor alongside the staff to help and support the team in role modelling their practices and delegating managerial tasks to the deputy manager during that period. Inspectors were informed of changes due to occur in the centre with staff leaving, an amalgamation of teams and new referrals to the centre while also dealing with escalating behaviours of a young person. The centre manager discussed these contributing factors and how the centre will manage all of those different aspects effectively through risk management.

Contrary to this, inspectors found that collective risk assessments were not in place and some social workers had not been informed of the amalgamation. Inspectors found that the centre required a detailed plan on how all of these changes would work cohesively, and this was not seen by the inspectors.

Inspectors noted the responses to behaviour management were consequence based and these were both positive and negative sanctions. Positive consequences included food vouchers, extra free time or a treat. Inspectors noted that the majority of these were monetary based, and the team must review these to ensure they respond to the behaviour presented as outlined in the centres policy. These were not affecting the behaviours and bringing about the required change. Inspectors were informed of a recent sanction put in place and how it was deemed ineffective. This was reviewed by a staff member and management and a new sanction was implemented that related to the behaviour presented. Inspectors found that from interviewing the staff, they were aware of their trauma informed response as their model of care and saw how the team looked for the root cause of the behaviour, however during interviews staff did not refer to their recognised behaviour management training or any other aspect as a response to positive approach to the management of behaviour that challenges.

Inspectors saw the young people's behaviour management approaches were discussed at team meetings, including areas of concern such as bullying, complaints and child protection concerns. There were actions identified which related to managing and monitoring the young people, following their safety plans and engaging in specific pieces of individual work. Inspectors found that the recording of the meeting didn't provide inspectors with clear enough evidence to assess if the appropriate guidance was provided to the team to address these issues.

When inspectors discussed the team meeting minutes with staff during interview, it was stated by staff that there was an issue with the minutes not being clear enough or well documented. This issue had been discussed at the team leader meeting but there had been no action put in place to address this yet. This needs to be actioned to ensure staff are aware of expectations following team meetings.

Inspectors were informed that supports were available to the team from the organisation's psychologist who linked with the team at different occasions such as team meetings, strategy meetings or for CICRs. Inspectors were informed by centre management that the care approaches and personal support plan documents were overseen by the psychologist and updates were made to the young people's relevant

documents including ICSPs, individual absent management plans (IAMPs), risk assessment and safety plans. However, inspectors found that the recording of the meetings didn't provide clear enough guidance to assess how these were overseen by the psychologist, as there was no signature or details about how the staff implement the recommendations from the psychologist into the above documents. Inspectors noted when reviewing the risk assessment books that the same risks were repeated sometimes up to 4 times daily. A care approach or a safety plan response would have been more appropriate in some of these circumstances.

When reviewing the young people's files, inspectors did not see the above documents reflect how the most concerning behaviour for one young person was being realised in practice, which was identified during interviews with the team, the guardian ad litem, and the social worker. This was regarding the young person's activities when they were on free-time and the potential vulnerability of the young person given recent known information. Inspectors were informed during interview with the social worker that a response meeting had occurred the day after onsite inspection and that changes were being implemented into a reduced amount of free time to help manage these concerns. The centre manager and staff team must ensure that all current concerns are identified across the relevant behaviour management documentation for the young people.

Inspectors reviewed work completed with the young people through key working and individual work around the behaviours that were being presented and saw that staff linked with the young people after incidents had occurred to reflect on those behaviours. For one young person, their behaviours were currently escalating despite staff interventions. However, it was noted by inspectors that previously the young person had responded well to linking with staff. The other young person was responding well to working with the staff and continuing to develop relationships with the team. There were supports in place for the young people for addressing any mental health concerns through local services.

Inspectors reviewed the collective pre-admission risk assessments that were completed for each young person prior to their admission and saw they highlighted where the levels of concerns/risks were based off a matrix system. The staff team reviewed the identification, assessment, and management of risk (IAMR) documents every two weeks or more regularly if needed. Improvements were noted for one young person as a decrease in some of those behaviours was noted, however there had been recent concerning behaviours that had not been reflected appropriately in the most up to date scoring in the IAMR regarding free time and drug use.

Inspectors reviewed an audit carried out by the director of compliance on the risk management documents which was completed in October 2022. Gaps that had been identified by inspectors were also picked up in the audit, such as some strategies referred to in the IAMR were the in future tense rather than what had happened/worked with the young people. It was also noted where a review of the scoring used in the IAMR was required to accurately reflect the ongoing risks. Inspectors did not see that these actions were implemented yet.

Inspectors received mixed responses from staff when asked if there were restrictive practices in place. Some staff said there were restrictions while others said there were none. The staff were aware there was a restrictive practice policy in place. The centre manager must review with the team what constitutes a restrictive practice. Bedroom door alarms and room searches were not deemed as restrictive practices by the staff and were identified as health and safety responses. Staff spoke of previous restrictions that were in place for ex-residents which included reduced access to razors and sharps. Inspectors found there was no restrictive practices log in place.

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

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

Actions required

- The centre manager must review the behaviour management policy and procedures with the team and ensure the staff have the appropriate knowledge and skills to carry out their duties.
- The centre manager and regional manager must ensure that the clinical guidance from the organisations psychologist is clearly identified and added into the young people's relevant documents.
- The centre manager must review the use of the risk assessment book and ensure the most appropriate risk documents are in place.

- The centre manager and staff team must ensure that all current concerns are identified across the relevant behaviour management documentation for the young people.
- The centre manager must ensure that the use of sanctions are reviewed with the team ensuring that they are relevant to the behaviours shown and in line with the centre's policy.
- The centre manager must ensure that the team meeting minutes clearly outline the discussions that have occurred in order for staff to be aware of what actions are required.
- The centre manager must review with the team what constitutes a restrictive practice.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2. Each child is supported to meet any identified health and development needs.

Both young people had their CICR recently, and both young people had their up-to-date care plan on file and had centre minutes on file. The health needs of both young people were identified in the care plan and the minutes. They had both completed a medical into care shortly after admission and had access to dental, optician and GP appointments when needed. These were written up by staff and stored in the young people's medical files.

There was some information missing from the young people's records around their childhood vaccinations which had been requested by the team on a number of occasions to the social work department. Requests had been made to family members for further medical information.

The young people were engaged with specialist services such as counselling, psychology and child, adolescent mental health services (CAMHS). One young person was offered supports for substance misuse however was refusing to engage with the local services available. This young person had previously been involved with another support service and there were recommendations and guidance pieces available for the team to help manage the young person's health and development

needs. Speech and language therapy (SLT) was one of the supports identified and inspectors did not see any follow up from the centre around sourcing supports for this service. Inspectors were later informed that the young person was refusing to engage in SLT so therefore they had not sourced the support. Staff had identified substance misuse support services for the other young person would be beneficial and were following up on this.

Both young people were linked with their family GP and inspectors saw regular contact with GP's and hospitals to address the health and medical needs of the young people. Staff had been trained recently in the use of medication related to epilepsy and had undertaken training around drug use and awareness. Both social workers and GAL informed inspectors they felt the health and well-being needs of the young people were being addressed by the team and they were appropriately informed by the staff with regular updates.

Staff informed inspectors they had recently completed medication management training. There had been no medication errors identified recently and staff were aware that a significant event would be sent if one occurred. Inspectors reviewed medication administration sheets and noted that two medications were due to be given to one young person at a particular time at night, however this medication was given repeatedly up to 2 hours after the identified time with no other directions known about a possible timeline of when the young person should be given the medication. All of the full-time staff had undertaken first aid training and one relief staff member required this training who was new to the team.

Compliance with regulations	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 4.2**
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

- No actions identified.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must review the complaints processes with the staff team to ensure they understand the procedures involved and that all staff follow it.	The director of services and the director of compliance will oversee workshops with the team on 16/2/23 & 2/3/23 to fully review and understand the Complaints Policy and Processes with the team.	Going forward, on Induction the workshop will be completed by all staff. During Audits Senior managers will ensure to interview staff on policies to ascertain their understanding of policies and processes. and in particular the complaints process.
	The centre manager must ensure that the complaint forms state the outcome of the complaint, the most up to date information of what has been completed and the feedback from the young person on how they felt about the response they received. This information must also be reflected in the complaints register.	The new Complaints Form revised following an Audit in July has yet to be implemented as we had not had a complaint between the audit and the Inspection. The new form contains this guidance mentioned here regarding how the young person felt about the outcome and to reflect the register.	The above workshop will be designed to fully implement and understands the new form and marrying the document to the registers. The Senior Management Team will also, through the process of audits ensure that that the process is followed as per policy.
	The centre manager must ensure that all relevant details are included in the	This booklet was fully reviewed in October 2022, that took into consideration from	The SMT will ensure that any further reviews take into consideration the key

	young people's booklet regarding the complaint's procedures.	previous inspection: to avoid too many words – the focus then is on the Journey Through Placement where young people are fully updated on the process. This has now been added to the booklet.	factors that young people need to be made aware of and balancing that with information overload.
3	The centre manager must review the behaviour management policy and procedures with the team and ensure the staff have the appropriate knowledge and skills to carry out their duties. The centre manager and regional manager must ensure that the clinical guidance from the organisations psychologist is clearly identified and added into the young people's relevant documents. The centre manager must review the use of the risk assessment book and ensure the most appropriate risk documents are in place.	The director of services and the director of compliance will oversee workshops with the team on 16/2/23 & 2/3/23 to fully develop their skills and review and understand of the Behaviour Management Policy and Procedure. We have scheduled a meeting with the organisations psychologist to discuss how we can identify the specific valuable guidance given by the psychologist in the young people's documentation and where this information is recorded. The Director of Compliance is developing a training video to ensure that the team understand what they are being asked within the document and explore the use	Going forward, on Induction the workshop will be completed by all staff. Through the processes of auditing, we will ensure to interview staff along with system review to identify any learnings or further development opportunities. The SMT will ensure oversight and Governance on the psychologist role and that the excellent guidance and relevant information is being recorded within the young people's documentation. This will be captured by director of compliance during themed audits. Through the audit process staff will be interviewed as well as paperwork review to ensure that they understand the risk assessment documentation.

		of more appropriate documents to address an ongoing behaviour in consultation with social workers.	This training video will form as part of our induction process.
	The centre manager and staff team must ensure that all current concerns are identified across the relevant behaviour management documentation for the young people.	A full review of IAMR's has been completed by centre manager and director of compliance. Learnings will be brought to the team meeting on 12.01.2023. Focused discussions will be had during the case management process.	SMT will ensure that in the event of any significant changes or increase in risk that these are identified across the relevant behaviour management documentation for the young people.
	The centre manager must ensure that the use of sanctions are reviewed with the team ensuring that they are relevant to the behaviours shown and in line with the centre's policy.	A review of sanctions has been conducted by the centre manager and the director of compliance and we have identified a specific time in this week's meeting 12.01.2023 to discuss learnings and review policy.	Centre Mangers to critically review sanctions in a bimonthly basis- this has been put in the agenda for Monthly Managers Meeting's going forward. Through the process of auditing, SMT will ensure confidence and compliance around same.
	The centre manager must ensure that the team meeting minutes clearly outline the discussions that have occurred in order for staff to be aware of what actions are required.	This had been identified by the SMT and addressed this with some staff members. There was a specific occasion related to the professional development of a single staff member and was in process of being supported around this.	We will ensure that the action plan in all meetings accurately reflects discussion. Centre Managers will ensure that a review of minutes is completed as soon as is practicable after all team meetings.

	The centre manager must review with the team what constitutes a restrictive practice.	The director of services and the director of compliance will oversee workshops with the team on 16/2/23 & 2/3/23 to fully review and understand the Policy on Restrictive Practice and what constitutes a Restrictive Practice.	Going forward on Induction the workshop will be completed by all staff.
4	No actions identified.		