Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 177

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Pathways Ireland**
Registered Capacity:	**3 young people**
Type of Inspection:	**Remote announced**
Date of inspection:	**25th & 26th January 2021**
Registration Status:	**Registered from 23rd September 2020 to the 23rd September 2023**
Inspection Team:	**Catherine Hanly** **Linda McGuinness**
Date Report Issued:	**9th April, 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 24th of August 2020 for the specific purpose of providing a special arrangement for one young person. It was again registered on the 23rd of September 2020 with a capacity of three young people. At the time of this inspection the centre was in its first registration and was in year one of the cycle.

The centre was registered at the time of the inspection without conditions to provide care for three young people aged thirteen to seventeen years on admission, on a medium to long term basis. The centre had a clear statement of purpose that stated its approach to service delivery as representing best outcomes for young people, opportunities to achieve goals and build on strengths in a homely and supportive environment. There was one young person residing in the centre at the time of commencement of the inspection and a second young person moved in whilst the inspection process was ongoing.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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. Due to an escalation in the numbers of positive cases during the Covid-19 pandemic, a risk assessments conducted by the inspectors and their line management determined that it was safest to conduct this inspection on a fully remote basis.

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 18th of February 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 2nd of March. 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: 177 without attached conditions from the 23rd of September 2020 to the 23rd of September 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

The registered provider had recently updated the entire policy document for the centre to ensure compliance with the National Standards for Children's Residential Centres 2018 (HIQA) and to reflect the centre's new model of care. The child protection policy was appropriately detailed and was found to be in compliance with the policies outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017 and relevant legislation including the Children First Act 2015. The policy document also included a range of relevant policies and procedures that were in place in the centre to protect children from abuse. Inspectors found through staff questionnaire and interview that staff and management were familiar with all relevant guiding legislation, standards and policies as it pertained to child protection. Staff also had a thorough understanding of safeguarding and their respective roles and responsibilities in ensuring that all young people in the centre were kept safe. The staff training record maintained evidenced that staff had completed a one-day training course in child protection however training in the Tusla E-Learning module: An Introduction to Children First was not included in this record. The centre manager must confirm with inspectors that this training module has been completed by all staff in the centre.

The centre had a written policy and procedures on bullying that was consistent with Children First and was inclusive of the approach to responding to this behaviour should it arise in the centre. The centre's complaints policy was also referenced alongside the policy on bullying and staff were cognisant of realising the 'young person-centred' aspect of their model of care through encouraging them to have their voice heard on all aspects of their care.

The centre had a Child Safeguarding Statement (CSS) that had been issued to the centre in December following several requests by the centre management to the Tusla Child Safeguarding Statement Compliance Unit. This statement was found to be compliant based on the information provided at that time however will need to be reviewed and amended as it referred incorrectly to another centre within the

organisation and will also need to identify the change in management with the acting manager as the deputy Designated Liaison Person (DLP) for the centre. Staff members were aware of the organisations DLP and the manager's role as deputy DLP and their respective responsibilities relating to child protection practices and procedures in the centre.

The acting manager and staff members demonstrated a clear understanding of the risk assessment processes in place which assisted the identification of individual risks and vulnerabilities and allowed plans to be devised to meet these needs in a safe way within the centre. Areas of vulnerabilities were risk assessed and individual behaviour support management plans were implemented as necessary. Individual work had been completed with young people to assist and support them in developing the necessary skills for self-care and protection. Both social workers confirmed that individual vulnerabilities had been discussed with centre management at the outset of their respective placements and that these would be appropriately considered in placement planning.

There was evidence from interviews and in records reviewed that the centre worked in partnership with social workers, and families where possible, as well as other relevant professionals to promote the safety and wellbeing of the young people resident.

The centre had a child protection and welfare report form register which inspectors reviewed. There were three separate entries in this register and none of these had been deemed to be closed. The centre manager had made contact with relevant social work departments for updates on these matters and must ensure that they continue to actively pursue them for the purpose of securing a response and/or outcome to the concerns reported.

The centre had a policy on whistle blowing in the employee handbook and staff were familiar with this and confident to use it if a situation deemed it necessary. Staff also expressed the view that management were approachable and available and they were confident that they could raise any issue directly with any member of the management team.

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

The centre's recently developed model of care outlined a positive approach to the management of challenging behaviour which included the elements of young person-

centred, attachment and trauma informed care and therapeutic interventions. The centre had a detailed written policy on managing behaviour that described a holistic approach and was inclusive of a wide range of other relevant policies including keyworking, consultation, young people's rights, risk assessment and staff supervision. The staff team were very familiar with, and were able to accurately describe in detail, this holistic approach and the various policies that informed the approach in the centre. They clearly expressed each young person's right to be central to all decisions made. The management team have access to dedicated clinical support from a psychotherapist on a monthly basis. The clinical support person provides feedback and specific therapeutic plans for individual young people based on information provided by the manager and staff team. They also make available relevant resources to the team. The acting manager and staff team consistently referenced this person as a significant source of input and direction.

The staff team had completed training in a recognised model of managing behaviours and were due to complete refresher training shortly after this inspection took place. Young people had individualised behaviour management and crisis management plans (ICMP) that were referenced by staff as being an important guide in informing their approach to and interventions with young people. Inspectors did note some deficits in the ICMP's in relation to the absence of commentary on the use of physical interventions. Where crisis behaviours had been displayed by young people, staff had conducted life space interviews to assist young people in understanding their behaviours and also to attempt to help them learn techniques that would enable them to manage these behaviours better in future. The management team within the centre participated in monthly significant event review groups. Records of minutes from these meetings demonstrated evidence of discussions around what worked well or not and whether identified interventions were utilised. Inspectors found that additional measures such as clear identification of what actions may be required to better support staff in situations of persistent challenging behaviour would lend themselves to improving this system of oversight and in turn the management of such incidents.

Social workers for both young people had participated in detailed pre-admission risk assessment processes for each of the young people and centre management were satisfied with the level of information provided in order to inform this process. Social workers for resident young people had been consulted with by centre management prior to the admission of further young people. Both social workers were satisfied with the level of appropriate information sharing that had occurred at that juncture.

The staff team did not demonstrate a consistently clear understanding of what constituted a restrictive procedure and inspectors found that there was not a specific policy on this area of practice separate to the use of permissible sanctions. Inspectors received conflicting information regarding whether or not there were any restrictive practices in place at the time of the inspection and there was none documented on the behaviour management plan reviewed by inspectors. The staff team were also unclear about whether or not physical interventions could be utilised with the two young people residing in the centre. As stated earlier, there was no reference to the use of physical interventions on the respective individual crisis management plans (ICMP). There had been no incident that required a physical intervention since the centre commenced operations however the use, if necessary, should be clearly documented on ICMP's. Conversely if there are valid reasons for not physically intervening with a young person, this should also be clearly stated on the ICMP. A specific policy on the use of restrictive practices should be developed and implemented with a clear understanding then shared amongst the staff team. Where restrictive practices are utilised these should be clearly documented across all relevant records, should be consistent with the young person's risk assessment and should be subject to regular review.

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Inspectors found evidence across interviews and records to indicate that the organisation promoted an open culture whereby young people and staff members could raise concerns or voice their opinions with regard to service improvement. This openness also extended to social workers of young people and their family members. The acting manager cited a recent experience of a young person having been discharged from the centre whereby the management team had the opportunity to receive feedback from the social work team on the placement. The acting manager also noted that there is the opportunity for family members to provide feedback with regards to service delivery and that this would be taken on board by management, this was mirrored in the centre's policy on complaints. The staff members identified the centre's management team, both internal and external, as being approachable and available and were confident that any issues raised would be taken on board and responded to.

The centre had a detailed policy and clearly identified procedures on significant events which included the identification of what constituted a significant event, the notification system in place, and how these events would be recorded, responded to and managed. Inspectors found that all aspects of this policy were clearly reflected in practice, from prompt recording and notification through to management and review.

The policy did state that events would be reviewed but did not specify the manner in which this would happen via the significant event review group. This policy should be amended to reflect the operation of this group and how learning from this forum is shared with the staff team and implemented in practice. Inspectors finding in practice was that the registered provider was ensuring that any learning arising from incidents was used to inform and develop best practice and so should take action to amend the policy to ensure it accurately reflects practice in this area. Both social workers stated that they were satisfied with the system in place describing it as prompt with an initial call or email to alert to an incident followed up by a detailed report. Social workers commented that management liaised with them on a regular basis and sought their views as appropriate. They were satisfied with the level and type of communication with the centre.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.1**
Practices met the required standard in some respects only	**Standard 3.2** **Standard 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- Centre management must develop a policy on restrictive practices and ensure that all staff are familiar with it and that the use of such practices are appropriately recorded and regularly reviewed.
- Centre management must amend the centre policy on significant events to include the role and influence of the significant event review group.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations,

national policies and standards to protect and promote the care and welfare of each child.

The inspectors were informed that the centre's suite of policy documents was being developed by a working group comprising members of the senior management team and in consultation with the centre managers and staff teams across the organisation. Notwithstanding the required additions in respect of restrictive practices and significant events outlined under Theme 3 of this report, inspectors found that this document was in compliance with the requirements of regulations, relevant legislation, national policy and the National Standards for Children's Residential Centres, 2018 (HIQA). Senior management stated that the revised and updated policy document would be finalised at the end of quarter 2 of 2021 and training would be delivered to all grades of staff across the organisation. The registered provider will need to implement a regular and formal review of this document after that time to ensure it remains compliant with national policy and legislation. The process for the development of these policies was inclusive and wide-ranging, with clear communication throughout. In addition, policies were discussed on a regular basis at team meetings. Inspectors found that all staff members were aware of and knowledgeable regarding the policies as well as relevant legislation and were confident in their understanding of their application to their day to day work.

Staff in the centre were familiar with the content of the centre's child safeguarding statement. They had a clear understanding of their respective role and responsibilities as they related to the implementation of Children First in their practice. Policies and procedures relating to the care and welfare of children were found to be in compliance with the requirements outlined under Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015.

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.

There was evidence of strong leadership in the centre by the acting manager who had been appointed three months prior to this inspection. Staff clearly stated a confidence in the acting manager and acting deputy manager as well as with all personnel at senior management level within the organisation. Inspectors found a keen focus on service improvement and quality of safe care practice. There was a

culture of learning and development which was particularly evident in team meetings.

There were clearly defined governance structures and arrangements evident in place within the organisation that set out the lines of accountability and authority. The acting manager and staff interviewed were clearly aware of their respective roles and responsibilities. The acting manager was responsible for conducting regular self-assessments which in turn were used to inform the audit reports generated by the complaints and compliance officer. There was evidence that the director of services and complaints and compliance officer within the organisation had visited the centre on occasion to review records, conduct audits and meet with staff and young people. This level of onsite activity had been impacted by the Covid-19 pandemic however audits of and regular contact with the centre had continued uninterrupted on a remote basis. In addition, the senior management personnel had access at all times to all information generated by the centre on the organisation's information technology system. Allocated social workers for the young people resident expressed their satisfaction with the care being provided to the young people and good communication with the centre.

The acting manager had been appointed in mid-November to cover a period of maternity leave and had been involved in a thorough handover of tasks and responsibilities. They had been the centre's appointed deputy manager prior to this and also had previous experience at that level within another of the organisation's residential children's centre. The internal management structure, which comprised acting deputy manager and three social care leaders, was appropriate to the size and purpose and function of the centre. Where specific duties were delegated to identified persons, records of these were maintained in writing.

The centre had a service level agreement in place with Tusla, the Child and Family Agency. The service provides regular formal updates to Tusla on the operation of the centre and has regular communication with them. The complaints and compliance officer had recently completed an annual report for the purpose of demonstrating to Tusla that the centre is compliant with relevant legislation and national standards. This document was made available to inspectors, in draft format, for their perusal.

The organisation had a risk management policy which informed the approach to the identification, management and review of risks in the centre. Inspectors observed that there were a range of measures in operation to demonstrate the implementation of this policy at the centre including detailed pre-admission risk assessments for

young people which involved consultation with all relevant parties, individual risk assessments for young people as a situation arises and monthly reviews of significant events. In addition, the centre maintains a risk register and there is a corporate register maintained by the organisation that each centre can access to view. The centre specific risk register would benefit from additional detail under the heading 'risk type', as this denoted 'centre specific' and thus as an 'at-a-glance' document it is lacking in detail. The reader is instead directed, by way of a referencing system, to another record that includes the broader detail. Additional detail in the centre risk register itself would enable easier oversight for the centre manager and senior management. The audits and annual compliance report examined and reported on risk-related measures in place at the centre. Inspectors observed also specific risk assessment and implementation of Covid-19 measures in compliance with government direction and guidance.

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre had a statement of purpose in place which clearly described the model of service provision delivered by the centre. This statement included the relevant detail required by the national standards, including the centre's aims and objectives, services provided and the various policies that informed the care and services provided. The statement had been updated in December 2020 to reflect the new model of care being implemented across the organisation and inspectors found that the statement was already beginning to be reflected in practice and records. It also identified the organisational structure as well as the management and staff employed within the centre. The statement was publicly available and there was also a young person's information booklet. This version required a minor amendment to accurately reflect the capacity accommodated in the centre. A parent's and professionals copy of the statement of purpose was also available.

Training in the new model of care had been delivered to the management and staff team at the centre and inspectors found that there was a very clear understanding of this across the staff team. Inspectors noted that there were discussions on the model of care and its implementation reflected in team and management meeting. Centre management will need to ensure that a review and evaluation of the statement of purpose is undertaken as part of the centre's governance arrangements to ensure that services continue to be provided in line with this statement.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Inspectors found that the centre had established solid internal and external audit systems with the stated purpose of monitoring and evaluating the quality, safety and continuity of care provided to the young people and making the necessary improvements towards achieving better outcomes for young people. The acting manager had oversight of all paperwork generated by the centre; observed staff practice and engagement with young people; conducted staff supervision and was present at team and management meetings. The acting centre manager used a self-assessment tool to assess the centre's compliance with legislation and relevant standards. The compliance and complaints officer within the organisation had the principal function of conducting regular centre audits and in doing so assessed the centre's compliance with the organisations policies and procedures and the National Standards for Children's Residential Centres, 2018 (HIQA). In addition, this person reviewed all complaints generated within the centre. Audits generally made reference to the findings of the acting centre manager's self-assessment report and identified its purpose. Inspectors noted that the reports generally, but not always, identified whether or not the actions named in the previous report had been addressed. In one report it was noted that the complaints and compliance officer had found "insufficient evidence" of an action being completed yet didn't highlight whether further action was then required. These reports should consistently identify whether all actions named were addressed in full and if not, identify if there is further action, such as escalation to senior management required.

These audit reports were made available to the acting centre manager and staff team and all were aware of the role of the complaints and compliance officer and the purpose of these audits. The service director provides an additional layer of governance through their oversight of all relevant incidents, events and complaints at the centre. They have regular contact with the acting centre manager and are promptly apprised of any relevant event at the centre. These mechanisms enable the service director to assess on an ongoing basis the safety and quality of care being delivered in the centre as measured against the National Standards for Children's Residential Centres.

Inspectors found that all relevant information relating to complaints, concerns and incidents was recorded and acted on promptly. A review by inspectors of team, management and significant event review group meetings showed evidence of

analysis of these events for the purpose of learning and identification of any trends or patterns arising.

As stated earlier in this report, inspectors were furnished with a draft copy of the centre's annual review of compliance. This report reflected a thorough assessment of compliance against each theme of the national standards and there were no deficits or areas of improvement identified therein.

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

Compliance with standards	
Practices met the required standard	**Standard 5.1** **Standard 5.2** **Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- All audit reports must consistently identify whether or not previously identified actions have been addressed and if not, what further action is required.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	Centre management must develop a policy on restrictive practices and ensure that all staff are familiar with it and that the use of such practices are appropriately recorded and regularly reviewed.	The Policy and Procedure working group have developed a policy on restrictive practice. Completed December 2020 with new suite of policies and procedures.	The centre management and care team received the restrictive practice policy on 22nd of February 2021. Training is scheduled for the management and care team on Thursday 4th of March 2021 and will received regular training thereafter. Senior Management will review the policy on restrictive practice on a yearly basis or as required. All incidents of restrictive practice will continue to be logged in the register and is reviewed by senior and centre management.
	Centre management must amend the centre policy on significant events to include the role and influence of the significant event review group.	Senior and centre management reviewed and amended the policy on significant events to include the role and influence of the significant event review on 23rd of February 2021.	The centre management and care team received the updated policy on significant events on 26th of February 2021. The training and activity co-ordinator will complete training with the team on Thursday 4th of March 2021 and will

			receive regular training thereafter.
5	All audit reports must consistently identify whether or not previously identified actions have been addressed and if not, what further action is required.	The compliance and complaints officer will ensure that all reports going forward include a section on progress on recommendations from previous reports regardless of further action being required or not. This will ensure complete transparency between reports and provide clarity on any further action (if any) is required by centre management to ensure all recommendations are completed to a satisfactory standard. Additional section added to Audit Report on 23rd of February 2021.	An additional level of oversight will be applied to the review of compliance reports, all reports will be sent to the newly appointment service manager for review prior to the reports being disseminated to the centre.