An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 207

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Solis EMC**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**20th, 21st, 22nd March 2023**
Registration Status:	**Registered from 02nd September 2022 to 02nd September 2025**
Inspection Team:	**Anne McEvoy** **Lorna Wogan**
Date Report Issued:	**9th June 2023**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 02nd September 2022. 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 without attached conditions from 02nd September 2022.

The centre was registered as a multi-occupancy centre to provide semi-independent accommodation for three young people aged from 16.5 years to 17 years on admission. The aim of the centre was to support the young people as they prepared to transition to adulthood. The care approach was underpinned by Erik K Laursen's '*Seven habits of reclaiming relationships*.' The habits identified in this approach included trust, attention, empathy, availability, affirmation, respect, and virtue. The team aimed to provide young people with the opportunity to develop positive relationships with caring adults who would role model appropriate ways of dealing with emotion and the challenges of everyday life.

There were three 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
3: Safe Care and Support	3.2
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 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 9th May 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 23rd May 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: 207 without attached conditions from the from the 02nd September 2022 to the 02nd September 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 wellbeing and personal development.

The inspectors reviewed the individual care files for each of the three young people in placement. All available and relevant information in relation to the young people was received by the director of services at the point of referral. This information was shared with the centre manager and deputy manager for screening in terms of suitability. Referrals were further discussed with the team members. There was a strong emphasis on supporting the young people to understand the purpose and function of the centre and the semi-independent programme of care. There was a strong focus on getting 'buy in' from the young people to invest in the programme and understand the benefits of it as they prepared for leaving care. There was evidence of the young people's participation in the admission process setting out their rights, responsibilities and centre expectations. Collective impact risk assessments were completed for each admission and where similar risks presented within the resident group strategies to mitigate the risk occurring were identified. Consideration was given to facilitating appropriate timing between each admission to provide each young person and the staff team time to get to know each other and establish routines and relationships.

The inspectors found there was good attention paid to care and placement planning. Care plans were updated and on file for two of the young people. One of the young people had a statutory review following their admission and the care plan was on file. This young person was subject to a subsequent statutory review and the social worker confirmed that the care plan was being updated at the time of the inspection. The care plan reviews were undertaken in line with the statutory timeframes and dates for the subsequent reviews were identified on the care records. There was evidence of additional professionals' meetings undertaken as required.

Staff interviewed were familiar with the care plan for each young person and how the care plan translated into the placement and the individual work set out for each

young person. The placement plans were comprehensive and covered all identified area of need for each young person. The inspectors found that the placement plans were not user friendly in terms of being documents the young people could easily engage with. However, their placement goals/tasks were set out clearly in the individual monthly schedules and were discussed with the young people. Young people were also provided with the opportunity to read their monthly progress reports with staff.

There was evidence that placement plans and individual monthly schedules were live documents that were discussed at handovers, team meetings and in supervision with staff. There was evidence of robust oversight by the centre manager and the deputy manager of the individual care files and the quality of the individual work undertaken by staff. The managers had systems in place to ensure individual work as identified was completed and gaps and deficits were identified and plans put in place to address same. Team meeting records were comprehensive and evidenced the centres care and planning processes. An update on current care plans, preparation for care plan reviews and feedback to the team following care plan reviews was evidenced on the team meeting records. Placements plans were updated every six months and/or after each care plan review meeting.

One young person who was due to be discharged from care the following month after the inspection had declined any engagement with the Tusla aftercare service, the social worker for another young person planned to make a referral for an aftercare worker once the young person met the aftercare eligibility criteria and one of the young people had an allocated aftercare worker who had commenced work on the aftercare plan.

For two of the three young people the individual work evidenced discussions in relation to behaviour that challenges, safety and risk and getting the young people to look at more effective ways to manage feelings and situations of stress. One of the young people had declined to engage with the programme of care in the centre and the files evidenced the efforts made by staff to engage and support this young person. Additionally, this young person had declined all supports offered by the social work department. Planning for this young person's safe care was through regular strategy meetings, the local complex case forum, family welfare conference and close liaison with the Gardaí as well as high level notifications of concern to senior managers within Tusla.

The social workers and a Tusla case worker who was supporting one of the young people confirmed communication was effective and they were informed in a timely manner of any matters of concern. One social worker spoke about the communication being open and transparent with good clear systems in place to report and manage matters of concern. Another external professional highlighted the commitment of the manager, key worker and staff team to the young person they were supervising. There was evidence on the care files of all communications with the social workers and other external professionals. There was evidence that the centre manager followed up on key issues for the young people with the social workers and communicated the young people's needs as required.

Compliance with Regulation	
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 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

There were a range of policies, procedures and systems in place to promote positive behaviour and to guide staff to manage behaviour that challenges. Staff were familiar with the model of care and there was a strong emphasis on building relationships of trust with the young people to support them to develop the skills and resources necessary for moving on from care and into independent living. The staff had access

to a forensic psychologist to advise and guide the care approach in relation to young people as required. There were safety plans in place to manage more high-risk situations for some young people and these were subject to multi-agency and multi-disciplinary reviews.

There was evidence of good collaboration with the external professionals including the Gardaí in relation to promoting safe care. The inspectors found that Gardaí intervention was used judiciously by staff however the centre manager must ensure there are systems in place to monitor and review incidents where Gardaí are requested to intervene to manage behaviour. The centre managers, directors and social workers must be satisfied it is an appropriate intervention in all circumstances. There was evidence on the centre records of regular communication between staff and the parents and families where they were involved in their child's life. The staff interviewed displayed a good understanding of the individual needs of the young people as set out in their placement plans.

Staff were trained in a recognised research-based crisis management intervention system. There were systems in place to monitor staff training and refresher training as required including training on physical interventions. The director of services provided this training and had plans in place to refresh aspects of the programme incrementally to ensure staff developed competency in areas such as the Life Space Interview (LSI) and incorporating the learning from LSIs into the ICSPs. There was evidence that staff had a good understanding of the young people's behaviour and their responses to the young people were informed by an understanding of trauma and the impact of adverse life experiences. In light of the centre providing a specialised programme of care for young people moving into aftercare the inspectors recommend that additional training be provided to the team to assist them to support young people in relation to their mental health, self-harm, suicidal ideation and drug and alcohol misuse. An investment in specific resources and the development of a structured care leavers programme would further enhance the programme within the centre and the expertise within the team. The staff training folder reviewed by the inspectors was not structured in a manner that facilitated ease of access to information on previous and current training therefore the inspectors recommend the record keeping system is reviewed in this regard.

There were personal support plans developed for each of the young people and set out the agreed strategies to support the young people with routine behaviours and behaviours that challenge. These plans were subject to regular review and updated as required. The inspectors found that some aspects of the individual crisis support

plans (ICSPs) and the individual absence management plans required further input and amendments. The ICSPs identified agreed physical restraint interventions for some of the young people however staff stated in interview that the young people were not subject to any agreed physical restraint holds. The inspectors found that the absence management plans were not individualised to the young people based on the specific risks and vulnerabilities associated with their unauthorised absences from the centre or incidents where they were missing from care.

The external professionals interviewed confirmed that communication with the centre was effective and they were notified promptly of all incidents. There were robust systems in place for the tracking and oversight of significant events that occurred by the centre managers and the service directors. Significant events were reviewed at team meetings and at senior management meetings to ensure oversight and learning from incidents. There was evidence that the team were well supported by the directors when dealing with behaviour that challenges. The director informed the inspectors that the system to review significant events was to be further developed with focused meetings to take place on a quarterly basis at regional level.

There was evidence that staff rewarded positive behaviour and there were consequences for unsafe or disrespectful behaviour. Interviews with staff and one young person evidenced that consequences and rewards were reasonable, age appropriate, fair and used minimally. However, the systems in place to record rewards and sanctions was not maintained up to date therefore it was not a reliable system to enable managers to monitor consequences or rewards. The service director confirmed they would examine a more effective and efficient system to monitor this area of practice and evidence positive behavioural support and learning outcomes for young people.

The service director was responsible for undertaking auditing and monitoring of the services. At the time of the inspection a specific audit of the centre's approach to managing behaviour that challenges had not yet been undertaken. However, there was regular oversight of practice by the directors. They received and read all significant events, undertook regular visits to the centre, completed director governance reports and quality audits, reviewed the centre managers monthly audits, discussed significant events at senior management meetings and periodically attended team meetings. The inspectors found that the service directors had a comprehensive knowledge of the operation of the service and were familiar with the young people in placement and their presenting needs and associated risks.

The centre had a system in place to record restrictive procedures. There was one restrictive procedure implemented at the time of the inspection and this procedure was requested by the social work department and was subject to on-going review. The inspectors found that one restrictive procedure had previously been implemented for a period of time however this was not identified or recorded on the system as restrictive. The director of services confirmed that they had planned to review the whole area of restrictive procedures at the next scheduled management meeting to provide further clarity for staff and managers in relation to restrictive procedures.

Compliance with Regulation	
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 ensure there are systems in place to monitor and review incidents where the Gardaí are requested to intervene to manage behaviour.
- The service directors must further develop the in-service training for staff to ensure they further develop a level of competency and expertise in the provision of delivering a programme of care for care leavers.
- The service directors in conjunction with the centre manger must develop a more accessible system to evidence and track staff training.
- The centre manager must ensure that the ICSPs accurately reflect the current and agreed physical restraint interventions.
- The centre manager must ensure the absence management plans are individualised to the young people based on the specific risks and vulnerabilities associated with their unauthorised absences from the centre or incidents where they were missing from care.
- The centre manager must ensure that staff responses to particular behaviours are considered as to whether they are restrictive in their nature. Where

considered restrictive in nature they must be assessed as being required and subject to regular review.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The inspectors found there was effective leadership and governance arrangements were in place to deliver child-centred, safe and effective care. The inspectors found the governance and oversight of the work of the centre was robust at all levels from the service directors to the centre managers down to the social care leaders. The centre manager and the deputy manager were based on site five days a week during office hours. Senior management meetings took place every two weeks and there were regular internal governance meetings between the deputy manager and the social care leaders. Quality audits had been undertaken by one of the service directors. These quality audits identified areas for improvement and learning and were child focused and practice oriented. There was evidence of assessing the practice in the centre against the policies and procedures in place. Staff interviewed confirmed they received feedback from directors' visits and the quality audits through the team meeting. Another of the directors completed monthly service director governance reports and the centre manager completed monthly audits in terms of reporting on the operation of the centre in a range of areas. There was a mentoring leadership programme in place and the centre manager was supported and guided in their leadership role through this programme. The mentoring leader also undertook centre audits with clear action plans to support the centre managers on-going learning.

There was robust supervision of both staff and managers. Staff interviewed informed the inspectors that supervision to date was beneficial and meaningful to them in their work. There were systems in place to monitor staff supervision and ensure it was undertaken in line with centre policy.

The inspectors found there were written job descriptions for all grades and roles within the centre and staff interviewed confirmed they had received a job description and the expectation of them in their work was in line with their job description.

The centre manager was due to complete their recognised qualification in June 2023. The inspectors found there were a range of supports in place to support them in their role until they were fully qualified. Staff interviewed stated that the centre manager was supportive, accessible and provided clear guidance and direction in relation to their work. The inspectors found the internal management structure was appropriate to the size and purpose and function of the centre.

A service-level agreement was in place between a parent company and the Child and Family Agency. The company that governed the centre was sub-contracted by the parent company and arrangements were in place to provide evidence of compliance on a bi-annual basis.

A new suite of policies and procedures were developed and updated and in 2023. The policies took account of legislative requirement and the National Standards for Children's Residential Centres (HIQA), 2018 and there were systems in place to ensure that all team members understood and implemented the policies through induction and policy supervision practice.

The centre had a risk management framework in place and there were systems in place to identify assess, manage and review centre-based risks and individual risks associated with the young people's presentation. There was evidence that risks relating to the young people were discussed at team meetings and staff were made aware where risk assessments were updated following significant events. Staff interviewed were familiar with the risks associated with each of the young people and the inspectors found that all risks associated with the young people were appropriately identified and risk assessed.

There was a system in place to ensure that alternative management arrangements were in place for when the centre manager was absent. The deputy centre manager undertook the role and responsibilities of the centre manager when they were absent. At the time of the inspection there was not a clear system in place to record delegated management tasks to ensure accountability. This delegation of tasks was done either verbally or by email or within the supervision process. The service director informed the inspectors that the centre managers monthly auditing system had recently been further developed to include a section for recording delegated management tasks

each month, to evidence when tasks are delegated and to whom and the key decisions made.

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

Compliance with standards	
Practices met the required standard	**Standard 5.2**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- None

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

The centre had adequate levels of staff to fulfil its purpose and function. One of the young people interviewed by the inspectors confirmed there was a stable staff team in place and a sufficient number of staff on duty to meet their needs. The centre had three social care leaders which ensured there was one staff member at social care leader level on each shift. There was a balance of experience and skills set within the team and there was evidence that newly appointed staff were growing in confidence in their work. There were three staff on shift each day with two staff on at night with one of these staff providing waking cover. The centre manager had a panel of relief staff available to cover sick leave and annual leave as it arose and the centre manager used relief staff who were familiar to the young people.

The service directors were proactive in relation to recruitment of staff and had undertaken a number of initiatives to recruit staff. There was evidence that workforce planning took place at team meetings and at senior management meetings. The staff rotas and time sheets were discussed at team meetings. There was evidence of forward planning with arrangements in place to fill the post of social care leader where one of the social care leaders was due to go on planned extended leave.

There was a staff recruitment policy in place. There were no staff resignations since young people were first admitted to the centre. There were a range of measures in place to promote staff retention as outlined by staff and managers interviewed by the inspectors. Staff interviewed were positive about their experience of working within the service. There were formalised systems in place to provide independent feedback to the service directors about their experience of working within the service that informed service improvement strategies. The senior management meeting records and the inspector's interview with one of the service directors evidenced a focus on staff morale, job satisfaction and staff retention. There was a system in place within the service to undertake staff exit interviews which additionally helped to inform staff retention strategies.

There were formalised procedures for on-call arrangements at evenings and weekends. At the time of the inspection the on-call support for staff had been provided by the centre manager since the centre commenced operations. The service directors confirmed that a new system for on-call was planned for implementation in July 2023. On-call support at weekends would then be provided on a rotational basis between the centre managers and deputy managers rotated between across the region.

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

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

Actions required

- None

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	N/A		
3	The centre manager must ensure there are systems in place to monitor and review incidents where the Gardaí are requested to intervene to manage behaviour.	Team Meetings will be a core forum for reviewing Garda intervention following SEN's and this will be an agenda item as and when applicable. This will be reviewed with the collective team and appraised accordingly in terms of the benefit of the intervention. Commenced 19.04.2023	PSP to reflect appropriate response by centre team in order to exhaust all strategies prior to involving Gardai. Policies on behaviour management will be regularly refreshed at Team Meetings and Garda intervention will also be monitored via the Operational Management Meeting forum.
	The service directors must further develop the in-service training for staff to ensure they develop a level of competency and expertise in the provision of delivering a programme of care for care leavers.	The training needs will be identified and management will source relevant training. An independent consultant who focuses on the are of Leaving and Aftercare is attending the centre on 23rd May 2023 to meet with the team. Their role is being explored in terms of possible training delivery.	Continue to have a specific training programme based on training needs of staff in the centre.

	The service directors in conjunction with the centre manger must develop a more accessible system to evidence and track staff training.	The training folder has been reviewed and updated to reflect all training undertaken by the team. Completed on 12.05.2023	The PIC will ensure consistent oversight of the Training Folder via the PIC monthly audit process.
	The centre manager must ensure that the ICSPs accurately reflect the current and agreed physical restraint interventions.	All ICSPS have been reviewed and are up to date. Implemented on 06.04.2023	The ICMP will be reviewed monthly by the PIC and there will be oversight by the TCI facilitator.
	The centre manager must ensure the absence management plans are individualised to the young people based on the specific risks and vulnerabilities associated with their unauthorised absences from the centre or incidents where they were missing from care.	The organisational AMP has been updated accordingly and implementation is pending. Implementation to be in place by 01.06.2023.	The PIC and DPIC will ensure that these remain up to date via monthly reviews. This will be evidenced in PIC Monthly Audit Report.
	The centre manager must ensure that staff responses to particular behaviours are considered as to whether they are restrictive in their nature. Where	The Restrictive Practice Policy is currently being updated and will be refreshed with all the staff via Team Meeting and Supervision Forums. Management will	Restrictive Practice will be monitored via the governance and audit process.

	considered restrictive in nature they must be assessed as being required and subject to regular review.	have a full oversight of the implementation of restrictive practices and the review process. Date for completion 14.06.2023	
5	N/A		
6	N/A		