An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 034

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Confoveo Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**14th & 15th February 2023**
Registration Status:	**Registered from the 31st of March 2021 to the 31st of March 2024**
Inspection Team:	**Eileen Woods** **Sharon McLoughlin**
Date Report Issued:	**08/05/2023**

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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 in 2004. At the time of this inspection the centre was in its seventh registration and was in year two of the cycle. The centre was registered without attached conditions from the 31st of March 2021 to the 31st of March 2024.

The centre was registered to provide care to a maximum of four young people aged between twelve and eighteen years on admission, admissions under the age of twelve were completed through a derogation process administered by Tusla ACIMS. The centre implemented the Welltree model of care for planning and outcomes and the centre described its model of care as trauma informed and therapeutic in approach. There were four young people resident in the centre at the time of this 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
6: Responsive Workforce	6.3

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 28th of March 2023 and to the relevant social work departments on the 28th of March 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 11th of April 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: 034 without attached conditions from the 31st of March 2021 to the 31st of March 2024 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.

Inspectors conducted an unannounced inspection of this centre and found that the files for each of the four young people were on the whole well organised and evidenced good oversight practices by assigned team members regarding items required for the file. For example, sections were identified for action regarding printing of updated monthly records for files and regarding absent copies of care plans. Four young people between the ages ten to sixteen were living at the centre, two long term and two more recently admitted in the latter part of 2022. Of the four young people one had the updated care plan on file from the most recent statutory review and the minutes of child in care reviews were on file for the three other young people. There was evidence on file of communication with the social work departments involved by the senior management team and responses had been received explaining the delays. All delays related to the absence of social work team leaders and/or administrative support to create and sign off the plans in order for them to be issued. The social workers involved detailed to inspectors the dates by which all updated care plans would be provided to the centre.

The care planning processes evidenced that the young people had been consulted with by their social workers and the team before their meetings. They were supported to attend the care plan meetings including the provision of an interpreter for the children who required same. The centre and the social workers, including newly assigned social workers had clarified the goals and actions required of the team at the centre and new meetings had been requested and booked for professionals to review the next steps where circumstances had changed.

The social workers all outlined good co-operation and a high standard of communication with the centre and found that the management and staff there had supported the young people well in their life and goals. Inspectors spoke with family members also who were satisfied overall with the level of contact with staff and how

they and their young person were supported. They also noted how they were warmly welcomed to the centre and invited to special events there. The family members knew the plans in place and the next steps that would be upcoming in hopefully advancing or clarifying the plans.

The referral and care plans for two of the young people did not reference a key element of the social work department plan. The social worker who took over the case stated that the care plans completed after that point and shortly to be provided to the centre did reference the up to date social work plan.

Placement plans were on file and the team updated these on a monthly basis. The actions from the care plans and the child in care review decisions were incorporated into the plans. A number of key areas were pending decisions and further meetings were due to take place in order to track progress towards the next steps. The two of the three families' inspectors were able to speak with were clear about the areas of change and were hopeful for positive outcomes.

Inspectors found that the placement plans overall supported tracking of progression and tasks, finding schools for example and thereafter supporting those school placements. The team utilised the Well Tree model of placement planning in a flexible manner and adapted areas for greater attention at key times such as independent living skills. There were some anomalies on the day of inspection with gaps in information regarding CAMHS involvement for a young person and the quality of the content of all four were not even, one young person's was not as up to date as others. Inspectors found that when a key worker was absent the team did not have the capacity to update the placement plans in their absence although that had been the intended goal.

As stated above inspectors saw evidence and heard from family and social workers about young people's involvement in their planning. Their voice was also noted within the placement plans. However, inspectors found that the approach to the young people's meetings required attention. These were held individually and one file had gaps in the records, the centre manager noted that records were pending for certain files. It was good to note that the young people's one to one meetings were used to provide positive support and praise but could be more dynamic and reflective of consultation overall including regarding young people's wishes. They should also be consideration to holding shared meetings to foster the shared living experience. There was a summary of young people's voice on the weekly reports sent to the social workers and on the daily logs.

There was one key worker assigned to each young person with oversight provided by a social care leader and there were efforts made to ensure young people's preferences could be accommodated. Key working records were maintained and inspectors found that whilst there was evidence of work being done and plenty of daily life activities, education, sport, family contact that some other elements were less evident. For example, it was more difficult to track some specifics being addressed like sex education or safety work regarding consistent sessions being planned or completed. Team meetings recorded and noted the processes around the key working and staff identified the team meetings and consultation sessions as important and useful in identifying and completing key work and individual work. There were good levels of attendance at team meetings and the young people were discussed in detail regarding how they were doing and what they needed.

On the day of the unannounced inspection inspectors observed the team having their monthly consultation with the organisation's dedicated psychologist. The team also accessed consultation monthly with the specialist in the model of planning, Well Tree, both reflected a focus on therapeutic care that took account of external professionals and a trauma informed approach. There was evidence of external professionals involved with two of the young people, one young person was actively engaged with this and the other opting not to attend at that time. The advice from the core professionals was contained within the relevant areas of planning, for example around active risk management or crisis support. The team clearly reported where progress had not been made and where risk remained elevated they communicated this information well to the external professionals. The team displayed good awareness of the complex trauma the young people carried.

There was evidence overall of a busy centre with a caring approach that had built and was further building good relationships and trust with the young people in their care. The team were challenged by a current deficit of one core staff member to bring the cohort of staff to nine full time personnel. Inspectors noted some items for attention on the day of the inspection and these were attended to by the registered proprietor and centre manager, there was a review of the fire doors required and replacement of one with repainting of the door and architrave required. A dented fridge door was agreed to be replaced due to its appearance. Photographic evidence of the completed works was provided. The house overall was well presented and homely aside from these items.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 2.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager and staff team must review their implementation of and approach to young people's meetings.

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 was good evidence found of continuity of care in the model and ethos of the centre, there was consistent support and leadership for a positive approach to behaviour support. This was evidenced through the management approach, the professional consultation provided and the daily planning. The focus was evident in placement plans, for example in supportive and positive bedtime routines, in promotion of sports and activities and healthy eating initiatives. There was support of family access and family contact with two families involved giving feedback to inspectors of good communication and respectful relationships. A family member noted that if communication ever slipped that they could contact the centre manager and it would be resolved. Inspectors found that the centres consulting psychologist focused on the purposeful use of positive interventions which was then implemented by the staff and reviewed thereafter.

There was a supporting policy and audits completed by the service manager identified areas of improvement which were then addressed through an action plan agreed with the centre manager. The service manager had completed a quality

improvement plan for 2023, signed off on by the service director, and this included a focus on quality assurance in the delivery of care through the national standards including positive behaviour support.

The staff team were trained in the therapeutic crisis intervention (TCI) model of managing challenging behaviours. Inspectors noted periods of time for new staff starting in late 2021 and early 2022 as having to wait a number of months for training and that some previous, though not the current, certificates for TCI refreshers were absent from the files, inspectors have asked that the personnel files be audited and the absent certificates located. Inspectors found that the two new relief staff who started in December 2022 were shortly to complete their full TCI training at the beginning of March 2023 evidencing that intervals to training completion had been improved.

The centre team identified and addressed behaviour management through a range of plans inclusive of behaviour management plans (BMPs), individual crisis support plans (ICSPs) and absence management plans (AMPs). Safety plans were also utilised, alongside risk assessments for situations requiring same. All had been reviewed on a monthly basis with more detail in specific areas where risk was highest. Where high risk pertained there was a clear three strike approach leading to named actions which were known by the young person, family, professionals and staff, these were recorded as appropriate in the restrictive practice records also.

Staff supervision of the combinations of young people when together in the centre was required at all times. The staff and the management all stated that supervision was constant when the situation required it and there was no evidence of issues in this regard. Inspectors expressed a note of caution that due to recent reductions in staffing numbers that it was a challenge to have a third staff on duty, this was confirmed through a review of the rosters. This was mitigated by extensive planned access and by the presence of the centre manager Monday to Friday, the weekend planners detailed two staff consistently on duty for two young people with a third young person having the potential to return. Whilst there were plans in place through the use of on call and relief staff availability this places pressure on sustaining good safeguarding practices over time. Staff were confident at interview about the supervision requirements being met on duty but did acknowledge that the house was busy.

The ICSP's for the young people whilst showing good knowledge of the young people contained unforced errors of content for two young people that were significant and

the same two ICSPs did not make explicit reference to restraint and if contraindicated or not. The IAMPs on file were individualised, detailed and of good quality. A family member and a social worker were partners in the protocols in place for a young person for whom this had been a significant issue and they detailed the reduction in missing episodes that had taken place. They noted that there was good communication when missing episodes occurred and rapid action taken leading to all parties being "on the same page". There were copies of the joint Garda and Tusla absence management plans on file also and these required signing by the relevant social workers.

The weekly reports that were sent to social workers looked at young people's current situation and progress made, they reported on any significant events that took place and the social workers confirmed that phone calls occurred in advance of receiving the written records. There was evidence of meetings being requested and convened where concerns escalated or where the focus of placements changed. There were regular significant event review group meetings held and actions identified from these were shared with the management who attended these meetings. Inspectors did not observe robust evidence of feedback being provided at team meetings or through supervision from these SERG meetings and these practices must improve.

There was a policy and procedure in place for restrictive practices. There were records on each young person's file of a range of restrictive practices, those in place for all four young people and those individual to specific young people. All were found to be related to safeguarding at the centre, and this was required. There was evidence of the two older young people having discussions with staff about specific restrictive practices in place and the reasons why. Inspectors noted the records didn't specify if an interpreter was used and not google translate only when explaining for the two younger children. The records supported that they understood that particular restrictions in place were by the request of their parents. The manager recorded and reviewed the restrictive practices on each file and inspectors recommend that the recording approach be made clear regarding start dates and review dates and the inclusion or not of the possibility of the use of restraint in an emergency. The records should also cross reference to or note the young people's views of same.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The centre management must review the individual crisis supports plans to identify and correct any errors and ensure that record management and audit systems are revised to protect against recurrences.
- The centre manager must ensure that the individual crisis support plans and the restrictive practice records identify if restraint is contraindicated and if not the possibility of its use in an emergency must be recorded and that young people know this.
- The centre manager and the service manager must ensure that the outcomes of significant event review group meetings are brought back to the centre staff to support learning and practice development.
- The centre manager must review the recording approach to restrictive practices to include start dates, review dates and to note views of young people following implementation of a restrictive practice.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

During this inspection two staff and the centre manager along with the service manager were interviewed. Inspectors found a grounded approach to care and a good level of professional knowledge with examples given of skills in practice

throughout the interviews. There were clear lines of accountability in the day to day work with all staff reporting to the manager and there were senior staff working on the roster including a deputy manager and two social care leaders. The deputy manager has historically worked as part of the roster and the centre manager worked Monday to Friday 9am to 5pm.

There were daily handovers and fortnightly staff meetings held which evidenced staff opportunity to organise and manage daily work as well as develop leadership skills. A staff described opportunities to advance their professional development and being supported in that by management. The staff had access to an employee assistance programme and a staff handbook, where they were lone working they planned appropriately and were aware of rest periods as well as safety at work.

At the time of the inspection the team had eight full time staff and two relief staff, recruitment had been ongoing including interviews on the day of the unannounced visit. The centre manager, the service manager and the service director outlined that they had been recruiting intensively during 2022 and since then with limited success and had adapted their recruitment processes to access a wider audience. Staff demonstrated an ability to be flexible and inventive to get all four young people where they needed to go and no access, school, sports or activities had been missed according to the records. Family members stated they were able to collect and return young people which assisted in mitigating some of the daily tasks.

The team meetings were well attended, including by relief staff and were held fortnightly as stated, each meeting included a consultation session generally as well as a general team planning meeting. There was a set format for this and the minutes maintained showed limited use of the sections on policy and procedures, complaints, significant event review group outcomes and group safeguarding was not well reflected on it overall. The minutes required improvement and the management must review the format to make best use of the aspects and areas they wish to highlight and review and how often. The fall in staff numbers did not come up at the team meetings as a concern for the existing staff.

Inspectors reviewed ten personnel files and found these lacked evidence of robust, regular audit. A list of actions were identified for completion or clarification and provided to the centre manager for action. There were nine supervision files available to review and currently five staff providing that supervision, although of those one was for student supervision. One day training in the provision of supervision had been provided. There was no supervisee training or briefings for

staff other than at induction or through their supervision contracts and this should be considered for all staff. Inspectors found a wide variance in the content, evidence of agenda items brought to supervision and regularity of supervisions sessions provided. The intended regularity was four to six weeks but some files in an eight month sample fell outside that range with the reasons for same not always recorded. The centre does not provide appraisals to staff and had just commenced creating professional development plans/PDP's, the appraisal process to inform the PDPs was not evident and the PDP's were undated in the main and unsigned.

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

Compliance with standards	
Practices met the required standard	**None Identified**
Practices met the required standard in some respects only	**Standard 6.3**
Practices did not meet the required standard	**None Identified**

Actions required

- The centre management must review and improve the standard of recording of and the use of dedicated sections on the team meeting format in order to better represent learning and reflective practices.
- The centre manager and service manager must take action on the audit and updating of the personnel files and implement a clear structure thereafter for their oversight.
- The centre management and the service manager must review the provision of supervision in line with its time frame and structure.
- The registered proprietor/service director must ensure that a system for the provision of appraisals is established and implemented at the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager and staff team must review their implementation of and approach to young people's meetings.	Effectively immediately, the centre staff will conduct monthly community meetings for all young people living in the home. These will be recorded in a centralised young person's meetings book under the specific heading "Community Meeting". The staff team will ensure the use of creative measures to encourage the attendance of all young people at these meetings including the use of fun activities to engage the young people.	The centre manager will add the review of the young person's meetings and the community meetings to their monthly audit. The deputy manager will be delegated the weekly oversight of the community meetings book and report any patterns of non-engagement to the centre manager. The service manager will incorporate the young persons meetings and community meetings in to their quarterly audit. Young Person engagement in weekly meetings and community meetings will continue to be discussed at centre team meeting and strategies implemented in the event of the identification of a pattern of non-attendance.
3	The centre management must review the individual crisis supports plans to identify and correct any errors and	The centre manager has reviewed and updated all ICSP's and corrected any errors found. This occurred 14.03.2023.	The ICSP's will be reviewed and updated by the entire staff team once monthly (or following incidents warranting change)

	ensure that record management and audit systems are revised to protect against recurrences.	A review of all current residents ICSP's will be conducted between the centre manager and the service manager. This is scheduled for 11.04.2023.	with the document being typed in real time for staff to have input into and all team members to sign off on. The centre manager will continue to review ICSP's as a function of the monthly audit. The service manager will continue to review ICSP's quarterly as a function of their audit.
	The centre manager must ensure that the individual crisis support plans and the restrictive practice records identify if restraint is contraindicated and if not the possibility of its use in an emergency must be recorded and that young people know this.	The centre manager has updated the ICSP for each individual young person to include that restraint can be implemented in the event of a severe significant event giving rise to risk of harm to the young person, other young people or staff members. The centre manager will meet with the young people to discuss rights, responsibilities and house rules and will incorporate a piece on restraint into these conversations in a child centred and age-appropriate manner. These meetings will commence the week of the 10th April 2023. Restraint has been added to the restrictive practice register by the centre manager	As part of the admissions process, the young people will be informed regarding the need to maintain safety in the centre and the possibility that staff members may need to maintain safety through the use of restraint. This will be communicated in a child friendly manner. The young person's booklet will be reviewed at senior management level to assess the appropriateness of incorporating restraint into the booklet and how to frame this in a child centre approach. Centre manager monthly audits, Service manager quarterly audits will be done. Significant Event Review Groups to discuss the outcomes of any possible implementation of restraint.

		27.03.2023.	Risk escalation meetings between the centre manager and the service manager can be convened by either party to review evolving risk.
	The centre manager and the service manager must ensure that the outcomes of significant event review group meetings are brought back to the centre staff to support learning and practice development.	The SERG meetings have been added to the team meeting agenda as a standing monthly item. The centre manager participated in a SERG 5.04.2023. The discussion from this SERG will be presented to the staff team at the next, non-clinical team meeting 18.04.2023.	The service manager and director will review the Policy on Significant Events and will update this to incorporate procedure on presenting the findings from SERG meetings. The SERG meeting minutes will be shared with the staff team prior to Team Meeting feedback, and the team will be encouraged to bring notes and ask questions. The SERG meetings will be added to the supervision agenda for the staff members for further discussion.
	The centre manager must review the recording approach to restrictive practices to include start dates, review dates and to note views of young people following implementation of a restrictive practice.	The centre manager has reviewed and updated the template for recording restrictive practices. This includes adding columns for recording the following: • Date Implemented • Date reviewed. • Date concluded. • Managers notes • Young person's notes	The centre manager will continue to review restrictive practices through their monthly audits. The service manager will continue to review restrictive practices as a function of the quarterly audit.

6	The centre management must review and improve the standard of recording of and the use of dedicated sections on the team meeting format in order to better represent learning and reflective practices.	The centre manager met with the minute taker to look at a professional development plan regarding recording of minutes.	The centre manager and the service manager will review the templates in use and make amendments to ensure higher outcome to reflection and learning. The service manager will schedule report writing and record keeping training for the team.
	The centre manager and service manager must take action on the audit and updating of the personnel files and implement a clear structure thereafter for their oversight.	A cover checklist has been added to the front of all personnel files to record all mandatory requirements for personnel files. At the time of the inspection, a centralised online system was being organised for launch to allow for online review of personnel files. This has now been completed as of 28th March.	The organisations use of a centralised, cloud based system allows for the centre manager and service manager to receive notifications regarding training expiry dates, employment documentation, Garda vetting, references etc which informs the senior management team on actions required. The organisation has the support of an administrative personnel that provides HR support.
	The centre management and the service manager must review the provision of supervision in line with its time frame and structure.	Effective immediately, only the centre manager and deputy manager will conduct supervision sessions with the staff team.	Following a senior manager meeting 30.03.2023, supervisions are to be scheduled 3 months in advance. The centre manager will continue to review supervision notes as a function of their monthly audit.

	The registered proprietor/service director must ensure that a system for the provision of appraisals is established and implemented at the centre.	The service manager and service director have provided an updated Staff Handbook to the team for review. This was provided on the 29th March 2023. We are awaiting feedback from the team for us to proceed on implementing this. The handbook included a system for staff appraisal and the time frames required for same. It is anticipated that the appraisal system will be ready for implemented by the 1st of May 2023.	The service manager has conducted a personnel file review to collate information pertaining to staff employment commencement, probationary periods and proposed appraisal dates in preparation for the rolling out of the new system. Once the updated handbook is approved and the appraisal system is implemented a schedule for appraisals will be drafted and sent to the centre manager by the service manager.