An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 113

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Odyssey Social Care**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**03rd, 04th & 06th of October 2022**
Registration Status:	**Registered from 11th January 2022 to 11th January 2025**
Inspection Team:	**Catherine Hanly** **Lorraine Egan**
Date Report Issued:	**21st December 2022**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 11th of January 2016. At the time of this inspection the centre was in its third registration and was in year one of the cycle. The centre was registered without attached conditions from 11th January 2022 to 11th January 2025.

The centre was registered as a dual occupancy service to provide medium to long term care for young people aged between 13-17 on admission. Their model of care at the time of the inspection, was based on theoretical approaches underpinned by four pillars of care delivery linked to goals of their placement; entry, stabilise and plan, support, relationship building and exit. The framework aimed to provide young people with stability, security, self-awareness, independence, self-sufficiency, appropriate coping skills and education. The organization was undergoing a process of change and were working on the development of a new model of care delivery. There was one young person living in the centre at the time of the inspection. It had been agreed between centre and social work management that this young person would remain in this centre on a single occupancy basis for a period of at least six months.

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
4: Health, Wellbeing and Development	4.2

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff and the allocated social worker. 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

Inspectors consulted with their line management following the completion of the inspection and assessment of findings. Inspectors confirmed that there was a deficit in the numbers of fulltime staffing contracted to work in this centre resulting in non-compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care Practices and Operational Policies. Additionally, there had been a high turnover of staff since the young person's placement commenced which was not congruent with the identified goal of stability. The national manager for Alternative Care and Education wrote to the registered proprietor requesting evidence of the plan to address these deficits. The plan was submitted on the 18th of October 2022 and communication was ongoing between the agency and the national manager at the time of issuing the final inspection report.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work department on the 18th of October 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The regional manager with responsibility for this centre returned the report with a CAPA on the 2nd of November 2022. 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 113 without attached conditions from the 11th January 2022 to 11th January 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.

There was an up-to-date statutory care plan on file for the young person, that was specific to this current placement, was well detailed and had clear actions identified within it. The young person had completed their own form which provided them with the opportunity to give input to this forum, which had been convened remotely via video call, as they had declined to attend. There was evidence across records reviewed and in interviews for this inspection that there was ongoing collaborative working to implement the actions identified in the care plan.

There was an up-to-date placement plan on file, this had been created initially on the young person's admission and then updated monthly. These plans named the main actions arising from the most recent statutory Child in Care Review and identified the main purpose of the placement for the young person as stabilisation. There was a clear mapping of the intended plan of action to achieve this primary aim with tasks identified. However, inspectors found that some tasks were vague and non-specific and there was insufficient evidence across records to support that concrete efforts and inroads had been made to achieve the identified goals. For example, daily living and predictability were identified as a task and a goal however the numbers of staff that had worked in the centre, twenty-eight, since the young person's admission ten weeks prior were not conducive to achieving predictability and stability. This level of change and disruption has also the potential to impact negatively on a young person's emotional wellbeing which must be given due consideration. Regarding daily living, some efforts had been made to implement structure and routine however evidence showed that the young person was not consistently engaging with this. The staff team were keen to give the young person choices in their daily living, but the young person regularly declined these choices and often opted for a third choice of their own making thus was not adhering to boundaries set by the staff team, was exerting significant control in many aspects of their life which was not evidenced as being beneficial to them. Centre management must ensure that the staff team are more

specific when developing the placement plan and include in it the identification of set tasks for staff members. This approach may then allow the team to better establish for themselves what works best for the young person within their current placement. It would also lend itself better to reviewing progress and outcomes achieved by the young person in the placement.

The young person's input was included and reflected in their current placement plan following a recent record of a discussion with a key worker that aimed to encourage them to put forward their goals for inclusion in planning. Although daily records showed evidence of regular conversations with the young person seeking their views on a range of matters from activities to education, to meal planning; their input was less evident in placement plans prior to this and staff could not describe how they were involved in their own placement planning.

There was a range of identified external and internal specialist supports that the young person could access should they be willing to engage. In addition, some of these specialist services were available to provide training and input to the team to assist them in working effectively with the young person. Inspectors found however, that the staff team were having to interpret and apply direction and advice from these various specialists, and it was difficult to see how this multitude of input was contributing to the main aim of the placement which was stabilisation. Rather, inspectors found it to be unnecessarily layered and complex as opposed to focusing on meeting identified needs in a consistent manner. Centre management must ensure that they utilise the next scheduled professionals meeting to clarify how best to apply the input of the identified specialists, with particular focus on the identification of one person to coordinate this.

Inspectors found evidence of good, purposeful, and regular communication between the centre staff and the social worker towards ensuring adherence to the aims of the placement as identified within the statutory care and placement plans.

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

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

Actions required

- Centre management must ensure that all young people are facilitated to participate in their placement planning process throughout the duration of their placement.
- Centre management must be more specific in the identification of placement goals and tasks for staff to achieve these so that a young person's progress can be readily tracked through their placement.
- Centre management must refine the input from relevant specialists and coordinate it so that it supports the team to ensure the young person progresses within the placement.

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.

The centre had a policy on promoting positive behaviour, including responding to behaviours that challenge. This policy was multifaceted and was not referenced by the manager or staff during interview as a document that guided their work at the centre. This reflects the finding of inspectors during the last inspection of this centre one year prior. Inspectors did not find a clear or consistently presented positive approach to the management of behaviour that challenges. There were a multitude of aspects to the management of behaviour that challenges presented during interviews for this inspection and represented in various documents on the young person's care file at the centre including role modelling, the use of the young person's window of tolerance, breathing techniques, lots of activity, efforts at stabilisation within the placement. However, the result of this was a confused and inconsistent approach that was not yet having any impact in terms of the main aim of the placement for the young person – stabilisation. Inspectors did see that there was a consistent practice

documented and reported of a calm, neutral-response approach to the young person when they became escalated. However, the deficit thereafter was in efforts to support the young person to understand their own behaviours that challenge and to learn more appropriate, respectful means of communicating their difficulties. There was a gap in knowledge for the team in identifying sexualised behaviours. Inspectors found that messages were being given to the staff team from management as well as external professionals of the need to accept the challenging behaviours presented by the young people. Where efforts were made by staff to communicate that some behaviours presented were not acceptable, this was deemed inappropriate by management. Inspectors found limited evidence of messages being communicated to the young person that would assist with their own growth and development about why their behaviour was deemed to be unacceptable and disrespectful to others.

As referenced earlier in this report, inspectors found that there was a wide range of input from the various professionals engaged to work with the young person directly and the team to support their practice and interventions; however, this was not being delivered in a cohesive manner and there was no sound evidence of any progression by the young person. Inspectors did not find robust evidence of reviews of behaviour strategies utilised, for example a token system, or the removal of bikes for use by the young person with staff. Therefore, staff had not determined effectiveness of interventions that they were being directed to implement.

Inspectors found an emphasis by management on the use of systems, specifically paperwork, at the centre. There was a wide range of documents referenced across records and contained within the care file, however staff did not reference any of these as guiding their work apart from the behaviour support plan (BSP).

There were some restrictive practices in use at the time of this inspection. These included an alarm system on the young person's bedroom door; pocket and bedroom searches; a parental app on the young person's phone and physical intervention which had been used with the young person. The use of these practices was recorded and although their review was referenced by the manager and documented in some records, this lacked detail therefore the process of the actual review itself was unclear to inspectors. In addition to the practices listed above, inspectors noted a reference in a key-working record to cutlery being removed from the kitchen following an incident and separately the bikes were removed from the young person's use. Neither of these were recorded as having been a restrictive practice and subject to review. Centre management must ensure that the use of all restrictive practices is recorded

clearly in the young person's care file and monitored on an ongoing basis to ensure that it is used for the minimum amount of time necessary.

All staff had received training in a recognised model of physical intervention and refreshers were scheduled for the coming months as necessary. Inspectors found that an incident involving the use of a non-routine physical interventions had not been clearly recorded separately and for the purpose of review. The records and reviews of incidents involving physical intervention were found by inspectors to be difficult to read with no clear learning/actions identified in the review record. Inspectors experienced difficulties in cross referencing entries in centre registers – for significant events (SEN's), child protection concerns, and episodes of the young person going missing – with the full record of the event itself. The company had a risk rating system for SEN's which in practice meant that only SEN's above a specified risk rating would be subject to review by the significant event review group (SERG), which consisted of senior management membership. SEN's not meeting that threshold were reviewed by the staff team and manager at a team incident review. It was difficult for inspectors to know from the records where changes were made because of the team incident review or SERG mechanisms and staff interviewed, although referencing the structures themselves, didn't describe them in a way that indicated they impacted on their practice. For example, one recorded incident which occurred over a period of approximately twelve hours and involved the young person displaying a range of behaviours that challenged, including a sexualised element noted that the sexualised behaviour was to be tracked across SEN's going forward. However, there was no awareness by the staff interviewed that this had been identified as a learning piece and it was difficult to see from the SERG record itself as it had not been stated as an action arising from the review. Centre management must ensure that all incidents involving a physical intervention are subject to a review by the SERG so that learning for all can be identified. Inspectors suggest that centre management engage with the social worker and their own internal trainer about the use of physical intervention to ensure that it is always appropriately used and reviewed.

A recent audit that by senior management found that life space interviews (LSI's) should be implemented more frequently and consistently. Inspectors were provided with an excel tracking format for management oversight of when these were attempted or implemented. However, it was difficult to track whether this was a consistently utilised practice for staff daily. Centre management must ensure that the staff team have a clear understanding of what aspects of the approach to the management of behaviour that challenges need to be implemented for the benefit of

the young person's progress. There must be clear systems of review that the staff team are active participants so that their use can be assessed for effectiveness, learning and mostly importantly, the progression of the young person within them placement.

Compliance with Regulation	
Regulation met /not 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

- Centre management must support the staff team in the appropriate communication to the young person regarding their behaviours in a way that supports their own growth and development.
- Centre management must implement robust reviews of behaviour management strategies utilised and ensure that any learning arising from same is understood by the staff team.
- Centre management must ensure that the use of all restrictive practices is recorded clearly in the young person's care file and monitored on an ongoing basis to ensure that it is used for the minimum amount of time necessary.
- Centre management must ensure that all incidents involving a physical intervention are subject to a review by the SERG so that learning for all can be identified.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

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

The up-to-date statutory care plan on file outlined the young person's current physical and mental health needs. Assessments had been undertaken in the past and,

at the time of the inspection, the social work team were progressing the matter of further assessment of need for the young person. It was hoped by the professionals involved that this would inform any necessary interventions and supports. A recent internal audit had identified that key working with the young person should focus on health and wellbeing, sexual health, mindfulness, and body systems. The action plan responding to this audit was noted as having all actions completed however these areas were not evidenced in key working records as having been comprehensively addressed. The centre manager, and line management, must ensure that where audits identify actions for completion that a clear plan of action is followed through to address these actions related to health and development needs.

The care record on file at the centre contained clear and complete information on the young person's medical and health information from birth. The centre had managed to successfully register the young person with a GP practice in the local area and they had their own medical card on file. The centre manager stated that securing the GP had taken some time and as a result, information had not yet been shared between previous and current GP's. The centre should update their 'hospital information form' on file to include the details of the current GP.

Several appointments have been made with the GP, a dentist, and an optician as per agreement and action identified at the most recent statutory Child in Care Review. The young person had so far declined to attend scheduled appointments. Inspectors suggest that a better account of these could be maintained in the young person's medical file – when offered, made, declined, etc. The young person had previously been offered the Covid vaccine and had declined it. Their medical file stated that they had "missed" the opportunity of the HPV vaccine. Centre management should ensure that further opportunities to access these are provided for the young person.

The centre had a policy on medication management and the young person was not currently on any medication. Previous medication prescribed had been withheld until a GP appointment and updated advice could be secured. There were clear records of daily medication counts maintained and weekly medication checklists on file. Two staff members were identified as requiring training in the safe administration of medication due to the upcoming expiry date for one and an already expired date for the second. Centre management must attend to this.

There was clear evidence of collaborative working by the centre and the social work department to ensure specialist services were accessed to meet the identified needs of the young person. As mentioned earlier in this report, there needs to be better

coordination of this specialist input to ensure a clear and consistent approach for the benefit of the young person.

Compliance with Regulation	
Regulation met	**Regulation 10**
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 4.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager, and line management, must ensure that where audits identify actions for completion that a clear plan of action is followed through to address these actions related to health and development needs.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	Centre management must ensure that all young people are facilitated to participate in their placement planning process throughout the duration of their placement.	The monthly placement plan of the 5th October 2022 was informed through discussion with the young person. Key-working session reflected input voiced by the young person which aligned with the placement goals.	Monthly as part of planned key-working all young people will be encouraged to participate in their own placement planning for the month ahead. These monthly key-working sessions will also be a forum for young people and their key-workers to reflect on the goals of the previous month and to review progress towards these goals.
	Centre management must be more specific in the identification of placement goals and tasks for staff to achieve these so that a young person's progress can be readily tracked through their placement.	A review of the placement plan was completed on the 05/10/2022. This includes each goal being broken down into planned topics and specific dates are set out for the key-working team to complete with set tasks assigned. An action from this review included retraining and support for the staff team in relation to key-working and placement planning.	Reviews of placement plans and young person's progress will be included in Team Meeting's to ensure that all staff are familiar with the young person's input into their placement plans, their progress and of the specific tasks required to support the young person in their placement. Monthly Service Governance reports completed by Centre Management include a review of Planning for young people and a review of

			placement plan progress and these Monthly Service Governance reports are overseen and signed off by the Regional Manager.
	Centre management must refine the input from relevant specialists and coordinate it so that it supports the team to ensure the young person progresses within the placement.	A Professionals meeting occurred on 05/10/2022 to discuss the provision of external agency supports to the young person with agreement made that additional supports would be provided. A review of internal guidance documents occurred on 2nd November 2022 and on review these documents were streamlined and aligned to ensure clear and consistent guidance is in place for the staff team.	Monthly Core Group meetings will now take place from November 2022 which will assess the effectiveness of specialist support in place to assist the staff team in working with the young person and to review the young person's progress in their placement. Monthly PBS plan meetings now take place which are attended by the Regional Manager, Centre Management, keyworkers, and the Behaviour Analyst. Findings and recommendations from these meetings will be discussed in team meetings and will inform key-working and placement planning for the young person.
3	Centre management must support the staff team in the appropriate communication to the young person regarding their behaviours in a way that supports their own growth and	The Life Space Interview (LSI) is identified as the main forum for this to take place to specifically assist the young person to connect emotions to behaviour. A Team Meeting was conducted on 29th September	Team Meetings will provide the forum for Centre Management and the staff Team to review strategies and interventions in place to support the young person. This will be guided by recommendations from Monthly

	development.	2022 which emphasised to staff the importance of completing LSI's and follow up planned key-working being utilised to support the young person in understanding their own behaviours and to support them in developing alternative coping strategies and ways of communicating their needs. Further training is scheduled for the 8th November 2022 for the staff team on conducting LSI's.	Core Group and PBS planning meetings.
	Centre management must implement robust reviews of behaviour management strategies utilised and ensure that any learning arising from same is understood by the staff team.	Behaviour Management documents were reviewed on 2nd November 2022 by PBS Analyst, Deputy Manager, Training Manager, Regional Manager, National Services Manager. From this review it has been highlighted that more correlation between documents to support the team is required. All documents will be streamlined by the 8th November 2022 to facilitate a clearer understanding by the staff team.	The process to ensure that learnings identified in review of incidents or improvements required in terms of behaviour management is clearly communicated to and understood by the staff team has been reviewed and updated. SEN review meetings will occur as required and will be attended by Centre Management and Senior Management. Where appropriate SEN reviews will utilise clinical and training department input as part of these reviews. The SEN review meeting will be recorded on an SEN review

			meeting form and all recommendations and findings will be reviewed by the staff team in Team Meetings.
	Centre management must ensure that the use of all restrictive practices is recorded clearly in the young person's care file and monitored on an ongoing basis to ensure that it is used for the minimum amount of time necessary.	Current Restrictive practices were reviewed with the young person's SW on 21st October 2022. On reviewing restrictive practices, door alarms were removed with remaining restrictive practices to be reviewed again on the monthly scheduled review with SW.	Restrictive Practice is reviewed with Social Worker once per month in a professional meeting with this review recorded in the young person's care file. Dynamic risk assessments that result in restrictive practice being implemented will be reviewed monthly as part of meetings between Centre Management and the Regional Manager. All restrictive practice reviews will consider best practice guidelines in relation to using restrictive practice for the minimum time necessary.
	Centre management must ensure that all incidents involving a physical intervention are subject to a review by the SERG so that learning for all can be identified.	All incidents involving physical intervention will be reviewed in an SEN review meeting which will be attended by Centre Management Senior Management and the TCI trainer. Learnings and recommendations from review meetings will be communicated to the staff team in Team Meetings.	SEN review meetings will clearly outline how findings from these reviews will be communicated to the staff team and will identify who is responsible for ensuring that learning for SEN reviews is shared with the staff team. All SEN reviews will be subject to review by the Serious Event Review Group (SERG). The SERG reviews

			will examine the effectiveness of the management of risk and will ensure that any recommendations are shared with relevant parties including the staff team and external professionals.
4	The centre manager, and line management, must ensure that where audits identify actions for completion that a clear plan of action is followed through to address these actions related to health and development needs.	Centre management have addressed deficits identified in the audit. Health and development needs are now a target area on the current placement plan.	The timeline for the closing out of Audits has now been extended to ensure that all identified actions including those related to the health and development needs of young people are completed in full. The Regional Manager will be responsible for ensuring that actions from audits are completed and will conduct an onsite visit to provide assurances that all actions have been completed.