An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 047

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Galtee Clinic**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Announced**
Date of inspection:	**13th, 14th, and 21st March 2023**
Registration Status:	**Registered from the 18th May 2021 to the 18th May 2024**
Inspection Team:	**Linda mc Guinness** **Paschal Mc Mahon**
Date Report Issued:	**17th May 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 18th May 2012. At the time of this inspection the centre was in its fourth registration and was in year two of the cycle. The centre was registered without attached conditions from 18th May 2021 to the 18th May 2024.

The centre was registered as a multi-occupancy service. It aimed to provide care to four young people from age thirteen to seventeen years on admission. Young people residing in the centre availed of a home style living environment with a small, dedicated, and flexible staff team made up of two-house pedagogues who reside in the centre on an alternating basis. Their work was supported by activity therapists who work alongside the house pedagogues on a daily basis in caring for the young people, overseen by the manager assigned to the centre and the service manager who has responsibility for the service as a whole.

The centre's therapeutic programme relied on a three-pronged approach of social pedagogy, attachment theory and therapeutic activities. The model was based on the development of therapeutic relationships with young people and was supported by the director of service who was a senior clinical psychologist. The primary attachment figure for the young people was known as the primary activity therapist. There were four young people living in the centre at the time of the inspection. Two young people were placed outside of the centre's purpose and function and a derogation was approved by the Alternative Care Inspection and Monitoring Service.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
3: Safe Care and Support	4.2
4: Health, Wellbeing and Development	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 5th of April 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 18th 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: 047 without attached conditions from the 18th May 2021 to the 18th May 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 1: Child-centred Care and Support

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

Inspectors found that there was child centred care with a focus on each young person and their individual needs. It was evident that there was a strong emphasis on young people's rights including their rights to be listened to and to participate in decisions about their lives.

Inspectors reviewed the records of young people's house meetings where they discussed issues such as group living, complaints and staff changes. Inspectors found that the records were limited and required improvements to accurately reflect the discussions that took place and follow up actions. Young people were involved in recording the meetings. While this was positive inspectors recommend oversight and additions to the record if required, to ensure there is full and complete record of each meeting.

There was a welcome booklet for young people introducing them to the organisation and house and this set out their rights, including the right to complain. The centre had more recently moved to an individual scrap book type approach specifically created for each young person depending on their age and understanding.

Inspectors viewed a range of documents including team and young people's meetings, complaints, daily logs, and key working records. The model of care was evident in practice and it was evident that young people were supported to develop trusting relationships with the adults that cared for them. The young people in the centre had a right to and, were encouraged to access information recorded in their files if they so wished however, they generally declined to do this.

There was evidence of clear, open and honest communication with young people. Decisions in relation to their care were explained to them according to their age and stage of development. It was evident that feedback from young people and their families was welcomed and was used to inform service improvements.

There was a complaint policy and procedure in in place which was consistent with the relevant legislation and regulations. It set out definitions of complaints, the stages, timeframes, specific roles and responsibilities, recording and the appeals process. The policy included reference about the Tusla *'Tell Us'* national feedback and complaints policy. Inspectors found that there was some confusion during inspection interviews about application of the policy and this is further discussed under standard 4.2.

Each young person was provided with a complaint package that set out who they could complain to internally within the organisation or externally through *'Tell Us'*, to EPIC (Empowering Young People in Care) and the ombudsman for children. Inspectors found however that the actual process of making a complaint, expected timeframes, and how they would be informed of the outcome or conclusion was not included. Management and staff confirmed in interview that this generally happened informally between young people, management and their primary activity therapists. A more robust system is required to ensure that there is evidence that young people are made fully aware of the complaints process. Information in relation to the complaints policy was emailed to parents and relevant professionals.

In line with policy, complaints that could not be resolved locally were notified through the significant event notification system. All complaints were recorded on a specific complaints register. There was evidence that complaints were taken seriously and responded to appropriately and in a timely manner. However, inspectors did not find a record of each complaint and the outcome on individual care files as required by the organisation's own policy and national standards.

Also, many complaints were resolved informally and concluded without any records. While this was understandable given the purpose and function of the centre and shared living spaces with community decision making, it did not facilitate tracking of less serious issues to inform learning and service improvements.

There was evidence that recorded complaints were monitored and reviewed by the centre manager and the service manager. They were discussed at team and management meetings and there was a plan by the recently appointed quality assurance auditor to review complaints under Theme 1 of the National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence of analysis of these complaints to identify trends or patterns. Staff in interview were able to demonstrate how learning from review of complaints informed changes to practice.

Inspectors reviewed the complaints on file and were satisfied that they were managed in line with policy and that young people were informed of the outcome.

There was evidence from speaking with young people and review of centre records that they were encouraged and supported to complain if they were dissatisfied with any aspect of their care. Staff and managers interviewed demonstrated an understanding of importance of a robust complaints policy and procedure to safeguard young people. There were occasions where staff made complaints on behalf of young people if they felt that they were unhappy with something or that their rights were not upheld.

Notwithstanding this, during inspection interviews there was confusion about notifying social workers of complaints through the SEN process and using the Tusla Tusla's *'Tell Us'* national feedback and complaints policy. Some staff understood these to be the same thing. While staff demonstrated strong advocacy for young people, inspectors found that they should have used the *'Tell Us'* procedure when there was a delay in allocation of a social worker to one young person. Also, it should have been used and when there was an unacceptable delay in funding a specialist service that was agreed through care planning and placement planning. It was first requested in August 2021 and remained outstanding 19 months later at the time of inspection, and unfortunately the young person was no longer interested in engaging with this support.

There was evidence that complaints by parents were managed appropriately in line with policy and that management communicated the outcome to them in a timely manner. Social workers confirmed they were notified in a timely manner of all complaints. In interview, they stated that they were satisfied that any complaints their young people made were managed appropriately.

The service manager and service director met with the young people regularly and enquired if they were happy with the care they received. Young people who spoke with inspectors were familiar with them and looked forward to interacting with them.

There was evidence from inspection interviews that managers had sought informal feedback from young people about the complaint's procedure. They regularly advised them of the complaints process guided them to external agencies that could support them or advocate on their behalf. Inspectors found that there was a robust and thorough investigation of a complaint made by a young person that was also reported under the whistleblowing policy and through the appropriate child protection

reporting procedures. There was evidence of organisational learning with policy and practice changes implemented following this process.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **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 1.6**
Practices did not meet the required standard	**None identified**

Actions required.

- The centre manager must ensure that there is evidence that young people are made fully aware of the complaints process as well as how to make a complaint.
- The centre manager must ensure that all staff are fully aware Tusla's 'Tell Us' national feedback and complaints policy and if necessary, support young people to make a complaint through this process.
- The centre manager must ensure that there are accurate records of each complaint and the outcome is held on individual care file as required by the organisation's own policy and national standards.
- The centre manager must ensure that all staff are fully aware Tusla's 'Tell Us' national feedback and complaints policy and if necessary, support young people to make a complaint through this process.

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.

Inspectors reviewed care files and found that statutory care plans identified each young person's physical and mental health needs. Two young people were placed in

the centre under a derogation to the purpose and function as they were under the stated age range. There was evidence that both social work departments convened monthly child in care reviews to comply with the National Policy and Procedure in relation to the Placement of children aged 12 years and under in the Care or Custody of the Health Service Executive. In the case of one young person there were delays in receipt of care plans following the review. There was evidence that the centre manager had escalated this issue appropriately within the relevant social work department to ensure all documents were available to facilitate effective planning including health needs.

Each of the young people had a medical card and were registered with a local general practitioner (GP). Where possible if the geographical location permitted, young people were facilitated to remain with their own GP. Young people in the centre were encouraged and supported to attend all medical appointments including dental, and ophthalmic services. There was evidence of a focus on overall physical and mental health and good communication between the centre and various medical practitioners. Previous assessments were held on young people's files as required. Inspectors recommend that if young people miss the HPV vaccine in a school setting that this is followed up and offered to them as a matter of priority.

Inspectors found that young people various health needs were identified through care planning, placement and aftercare planning however, there was a lack evidence of planned or scheduled work being completed with the young people to address these needs. It was not possible to determine from review of planning documents, team meetings or handover records that individual pieces of work were assigned to people. This appeared to be a recording issue, as there was evidence that work was being tracked by the centre manager who had written to individual staff to ensure accountability for assigned work that had not taken place.

While there was evidence of some therapeutic work taking place with one young person relating to mental health for example, significant improvements were required to evidence the individual work taking place with all young people in support of meeting identified goals. Staff in interview confirmed that age-appropriate discussions took place with young people about sex education and sexual health and drug awareness however as with other individual work linked to placement planning the evidence of this was limited. Some records of individual work required specific follow up however, there was no evidence that this was planned or recorded. There was a weekly handover when the social pedagogues changed over however this did not include placement planning. There was no record of daily handover that

evidenced a transfer of information or shift planning that included assigned pieces of work related to placement planning including health needs. Inspectors recommend that this is reviewed to facilitate more thorough tracking of the work taking place with young people.

There was good evidence of the work that the clinical psychologist was undertaking with young people and also of their support to the staff team to guide their work. Management and staff described this as a valuable source of professional and personal support. It was linked to the model of care and evidenced implementation of one of the key principles of reflective practice.

Staff were also encouraged and facilitated to attend internal and external training programmes to support their work with young people and this was evident on review of personnel files.

There was a confidentiality contract in place for staff members. Inspectors found that it was common practice for staff to share information relating to young people's health and other scheduled appointments in a shared group chat. Staff used their own personal phones to participate in this planning forum and while all stated that it facilitated effective planning there was no evidence of oversight to ensure that there were no breaches of data legislation whereby personal or sensitive information was shared or compromised. Senior management must conduct an urgent review and, if breaches are found to have taken place, must report these without delay to the data commissioner.

Social workers who spoke with inspectors were satisfied that young people's health needs were a priority and that they were supported to maintain a healthy lifestyle.

There was a medication management policy that was in line with the legislative and regulatory requirements. All social pedagogues and primary activity therapists had received training in the administration of medication and certificates were held on file. Records of administration of medication were up to date and in line with policy. No medication administration errors were recorded since the last inspection of this service.

Compliance with regulations	
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 must ensure that the placement planning process is reviewed and that needs/goals including health are specifically assigned to staff. This should be more clearly linked to handover and shift planning with staff held accountable for their work.
- The director of service must ensure a review of information held on mobile devices and shared communication, to ensure that there were no breaches of data legislation whereby personal or sensitive information was shared or compromised. If breaches are found to have taken place, they must communicate and report these without delay to the data commissioner.

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.

There was evidence that despite difficulty with high staff turnover and shortages in the sector, the registered provider made efforts to ensure that there was a consistent staff team with the necessary skills to meet the needs of young people. There was high turnover of staff in 2022 but there was evidence of robust discussions about workforce planning at senior management meetings. Inspectors found that there were sufficient numbers of staff to comply with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7: Staffing.

There social care manager was suitably qualified and experienced and held this post since March 2021. The centre had a staff complement of 4 full time social pedagogues (SPs) and 4.5 staff working as primary activity therapists (PATs). The SPs providing double 'live in' cover during evenings/nights and weekends alternating between two teams. The PATs covered day shifts in the centre between 8am and 10pm depending on the needs of the service. The staffing needs of the centre was fluid as one young person was away from the centre for up to four days a week and another for two days per week. Staffing was reduced during those times however when four young people were present there was always a ratio of 4:4 providing cover.

One staff member employed since 2018 was unqualified and this was outside their own organisational policies and professional staffing requirements of the alternative care inspection and monitoring service. Inspectors were informed that this person intended to pursue a social care qualification and at the time of inspection was enrolled to an online level 5 social care. Senior managers interviewed during inspection were aware that this would not meet the required level and described this as an entry point for achieving a suitable qualification.

There four dedicated relief staff known to young people who were available to cover sick leave, annual leave and other planned or unplanned leave as it arose.

A new middle management post of house leader was recently introduced and this person spent two days (up to 22 hours) in the centre covering shifts and two off-site in the office in support of management duties. Staff and management described this as a welcome development in respect of both governance and support.

There was evidence that workforce planning was built into the strategic planning for the organisation. In January 2023 all staff in the organisation were provided with updated benefits package in support of staff retention. These measures included a variety of incentives to reduce turnover and encourage stability and consistency for young people. These included, pension contributions, death in service benefit, income protection insurance, performance bonuses, extra annual leave allowances, length of service increments and opportunities for career breaks. Continuous professional development and training opportunities, membership of social care Ireland, an employee assistance programme (EAP), career progression with newly identified roles and staff wellness days were also included. Feedback from staff and management in interviews was very positive about these measures and a number of staff had made decisions to remain with the organisation as a result.

Staff and management described positive team morale at the time of the inspection Although there were significant staff changes in 2022 the young people were supported with this and always had identified key people assigned to them. There was evidence that changes were discussed with young people in their house meetings.

Inspectors reviewed a sample of personnel files and found that there were deficits in respect of recruitment and vetting that required immediate attention.
The qualifications on file were not appropriately verified on files reviewed. In addition, the organisation's recruitment policy stated that detailed notes of the interview process were kept on file however, this was not evident on any files reviewed during inspection and it was difficult for inspectors to determine how the organisation determined the suitability of candidates assessed.

Centre management informed inspectors that deficits on personnel files was highlighted internally at a recent management meeting and a plan was in place for the service manager to audit all files and to take appropriate action. There should be a system whereby staff personnel files are regularly audited to ensure all the required documentation is maintained on each file.

All staff had received Garda vetting in line with National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 -2016, and if relevant, police checks from other jurisdictions where they may have worked. However, Garda vetting had not been reviewed for some staff since 2018/2019 which is outside industry standard and best practice of renewal every three years at a minimum.

There was a system in place to conduct and evaluate exit interviews to inform service improvements however there were limited records of these during inspection. The service manager indicated that the system was under review as it was recognised it was not providing information as intended in the current format.

There was a system in place to record and track staff training. All mandatory and refresher training including Children First training was up to date at the time of this inspection. One staff member had completed external child protection training to include Children First National Guidance for the Protection and Welfare of Children, 2017 however, they had not completed Tusla's eLearning programme.

There was an on-call system in place to support staff at evenings and weekends. On call was provided during the week by the centre manager, and with other centre

managers at weekends. Staff were clear of thresholds for contacting the on-call person and reported that it worked well in practice.

Compliance with regulations	
Regulation met	**Regulation 6** **Regulation 7**
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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required.

- The centre manager must ensure that staff personnel files contain all required documentation and an up-to-date file is maintained for each staff member.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure that there is evidence that young people are made fully aware of the complaints process as well as how to make a complaint.	A complaints package has been developed and a copy given to each of the young people. This package contains a copy of the organisation's complaints form, summary of the complaint policy, the appeals process and external bodies to whom they can make a complaint- Tell Us, EPIC and Ombudsman for Children. Each young person has already received a complaints package, and these will be updated and reviewed with them at house meetings and scheduled IWR. Completion date of end of April 2023.	Complaints will be on an agenda of planned individual work which will be completed with each young person in a planned manner and occur at a minimum of twice per year- this will come into action immediately. Complaints will be a running item on agenda for house meetings.
	The centre manager must ensure that all staff are fully aware Tusla's 'Tell Us' national feedback and complaints policy and if necessary, support young	Tell Us' will be explained at team meeting on 18/04/23 and all staff made aware of how and when to use the portal to submit complaints or feedback through 'Tell Us'	Complaints will be reviewed regularly at team meetings and supervision to identify if they require to be submitted through the Tell Us portal.

	people to make a complaint through this process. The centre manager must ensure that there are accurate records of each complaint and the outcome is held on individual care file as required by the organisation's own policy and national standards.	Information on above will also be sent to team members- to be completed by 21/04/23. The escalation policy has been updated and emailed to the team which includes escalating issues or complaints that arise to relevant professionals and also using Tell Us where necessary. A record of all complaints will be held in individual care files and complaints register moving forward, effective immediate.	This will ensure that the team are confident in understanding how Tell Us works and that they use it for its intended purpose. The Quality Improvement Officer will conduct an audit on complaints to ensure this has been implemented- Audit will commence the week of 17th April and report will be received with recommendations by 1st of May 2023. These audits will form part of regular governance within the service.
4	The centre manager must ensure that the placement planning process is reviewed and that needs/goals including health are specifically assigned to staff. This should be more	A governance meeting was held on 03/04/23 to discuss placement planning. Placement planning meetings will commence the last week in April which will set out goals, planned IWR and	The individual work schedule will be discussed at team meetings and part of updated placement plan template. The revised placement plan policy was

	clearly linked to handover and shift planning with staff held accountable for their work.	scheduled IWR (complaints, online safety, bullying etc). These meetings have been developed to ensure that once all the above has been discussed and created, goals and individual work will be assigned to specific members of staff. Placement Planning meetings will take place every second month, and the following team members will attend/contribute; primary activity therapist, house leader, centre manager and social pedagogue. The goals will then be shared with the team and individual team members will be held accountable for completion of this work. Will be implemented by May 2023	shared with the team and discussed at team meeting on 18/04/23. Placement planning will be audited under Theme 2 as part of the general governance of the service. Placement plan audit for 2023 was completed on the 8th of March 2023.
	The director of service must ensure a review of information held on mobile devices and shared communication, to ensure that there were no breaches of data legislation whereby personal or sensitive information was shared or compromised. If breaches are found to	A review of mobile devices and shared communication will be completed and if any breaches are found they will be reported to the data commissioner immediately. ACIMS will be informed of the outcome from this review. to be completed by 31/05/23.	This issue will be discussed at management meeting and a decision will be made in relation to what method of communication can be used in future to ensure it is still effective while not breaching data or compromising personal or sensitive information. Any decisions that are made

	have taken place, they must communicate and report these without delay to the data commissioner.		in relation to the above will be communicated to the staff team upon completion.
6	The centre manager must ensure that staff personnel files contain all required documentation and an up-to-date file is maintained for each staff member.	Personnel files will be reviewed by Centre Manager before 1st of May and any outstanding documentation to be requested and received for personnel file before 1st of June.	The service manager will complete audit of personnel files in June 2023 and will provide feedback and recommendations to ensure files are up-to-date and contain all required documentation. These audits will form part of regular governance within the service. Checklist will be completed for any new employee for their personnel file.