Health Information and Quality Authority
Regulation Directorate

Monitoring Inspection Report on children's statutory residential centres under the Child Care Act, 1991

Type of centre:	Children's Residential Centre
Service Area:	CFA DNE CRC
Centre ID:	OSV-0004169
Type of inspection:	Unannounced Children Inspection
Inspection ID	MON-0021546
Lead inspector:	Caroline Browne
Support inspector (s):	Rachel McCarthy

Compliance with National Standards for Children's Residential Services

The inspection took place over the following dates and times:

From:	To:
21 March 2018 11:00	21 March 2018 17:30

During this inspection, inspectors made judgments against the *National Standards for Children's Residential Services*. They used three categories that describe how the Standards were met as follows:

- **Compliant**: A judgment of compliant means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation, if appropriate.
- **Substantially compliant**: A judgment of substantially compliant means that some action is required by the service/centre to fully meet a standard or to comply with a regulation, if appropriate.
- **Non-compliant**: A judgment of non-compliant means that substantive action is required by the service/centre to fully meet a standard or to comply with a regulation, if appropriate.

Actions required

Substantially compliant: means that action, within a reasonable timeframe, is required to mitigate the non-compliance and ensure the safety, health and welfare of the children using the service.

Non-compliant: means we will assess the impact on the children who use the service and make a judgment as follows:

- **Major non-compliance**: Immediate action is required by the provider to mitigate the noncompliance and ensure the safety, health and welfare of the children using the service.

- **Moderate non-compliance**: Priority action is required by the provider to mitigate the non-compliance and ensure the safety, health and welfare of the children using the service.

The table below sets out the Standards that were inspected against on this inspection.

Standard	Judgment
Theme 2: Safe & Effective Care	
Standard 10: Premises and Safety	Non-Compliant - Moderate
Theme 4: Leadership, Governance & Management	
Standard 1: Purpose and Function	Compliant
Standard 1: Purpose and function	
Standard 2: Management and Staffing	Non-Compliant - Moderate
Standard 3: Monitoring	Compliant

Summary of Inspection findings

The centre was an aftercare service which provided residential care for four young people aged 17 years and over. The aim of the service was to prepare young people for independent living and to provide support after the young person had left the centre. The centre's statement of purpose and function stated that the service aimed to provide a supportive environment to assist young people to transition to independent living. The model of care was characterised by building supportive relationships with the young people and putting them at the centre of the decision-making process.

As there were no young people under the age of 18 placed in the centre at the time of the inspection, inspectors focused on standards which related to governance and management, monitoring, statement of purpose and function and premises and safety.

During this inspection, inspectors met with staff members, the Centre Manager and spoke with the Alternative Care Manager. Inspectors observed practices and reviewed documentation such as policies and procedures, staff files, relevant audits, risk register and walked around the premises.

Inspectors found that not all management systems were effective. There was a well-established and experienced centre manager and staff team. There were good communication systems in place between the staff team. Staff were aware of their roles and responsibilities. The majority of staff were qualified. However, governance and oversight systems required improvement. External oversight by the alternative care manager was not effective in order to ensure that a safe effective service was delivered. The management of risk also required improvement. Risk assessments were not fully complete and had not been reviewed in a timely way.

The centre was homely and well decorated however, there were some delays in response to maintenance requests. Not all precautions against the risk of fire were fully implemented.

Staff were not supervised in line with national policy. Staff files were not up-to-date and not all staff had up-to-date mandatory training.

Inspection findings and judgments

Theme 2: Safe & Effective Care
Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs.

Standard 10: Premises and Safety
The premises are suitable for the residential care of young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care (Placement of Children in Residential Care) Regulations, 1995.

Inspection Findings

The premise was suitable for its stated purpose. The centre was based in a five bedroom house in a housing estate. It was situated close to local amenities and transport facilities. It had a small front garden space. Young people had their own bedrooms and there was space for visitors. There were suitable facilities for cooking and laundry and there was adequate heating, lighting and ventilation. The centre was homely and was decorated with soft furnishings and pictures belonging to the young people.

Maintenance requests were not always responded to in a timely way and records of requests were not up-to-date. The centre was generally in a good state of repair, however inspectors found that some requests were not responded to in a timely manner. Records of maintenance were not consistently up-dated or complete. As a result, it was not always evident if maintenance requests had been completed in a timely manner. For example, a request for a wardrobe door had been made two months previous and had not been completed.

Precautions against the risk of fire required improvement. There was a certificate of compliance with fire safety requirements and a fire safety policy available in the centre. There were adequate means of escape and prominently displayed signage and procedures for the safe evacuation of young people and staff in the event of a fire. Fire safety equipment was serviced and there were daily and weekly checks of the fire equipment. However, three staff members had not received up-to date fire safety training. There were regular fire drills and all young people had completed a fire drill in the last 12 months. However, two staff had not completed a fire drill. Furthermore, not all agency staff had taken part in a fire drill. The centre manager told inspectors that there was always a member of staff who had completed a fire drill on the rota. This was also confirmed by inspectors on review of the staff roster.

Medicines were safely secured in a secure cabinet.There was a new policy for the management of medication which was approved in October 2017. However, staff were in the early stages of implementing this policy. A number of staff required training in the new medication management policy before it could be fully implemented.

The centre had a closed circuit (CCTV) system which monitored and recorded the front of the house. There were signs in place to identify that CCTV was in use. There was a CCTV policy in place.

There was an up-to-date safety statement which was centre specific. This statement was read by all members of staff. Health and safety audits were carried out by a nominated person on bi-weekly basis. However, on review of these audits, inspectors found that some issues had not been resolved in a timely manner as the same issue had been identified on several audits.There were also several gaps in which health and safety audits had not been completed in recent months. The centre manager acknowledged that these audits were not consistently completed.

The centre was adequately insured. There was one centre vehicle which was adequately taxed and insured. There were also weekly checks completed of the vehicle to ensure they were adequately maintained.

Judgment: Non Compliant - Moderate

Theme 4: Leadership, Governance & Management
Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed. The system is subject to a rigorous quality assurance system and is well monitored.

Standard 1: Purpose and Function
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

Inspection Findings
The centre had an up-to-date written statement of purpose and function that accurately described the centres aims and the manner in which care was provided. The statement listed the key policies in place and the day to day operation of the centre reflected the statement of purpose and function. The statement of purpose and function was available in a form accessible to young people.

Judgment: Compliant

Standard 2: Management and Staffing
The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

Inspection Findings
There was an effective management structure in place. There was a full-time centre manager in place who was supported by an alternative care manager. The centre manager was qualified and was experienced in her role. There was a complement of 12 whole-time equivalent staff members on the team but there were five vacancies at the time of inspection. Staff were clear about their roles and responsibilities. There was a newly appointed deputy manager who was assigned specific tasks in order to support the centre manager.

There were no policies and procedures to guide the staff team in relation to the specific service they were providing. The centre manager told inspectors that they were waiting on revised policies and procedures in relation to providing a service to young people once they turned 18 years. This issue had also been identified in the previous HIQA inspection in August 2016 and was subsequently identified by the Child and Family Agency, Tusla, monitor in July 2017. While at that time, a review of policies governing centers which cater for young people over 18 was due for completion in August 2016, this review had not been completed at the time of this inspection. In the interim, staff and managers were following policies and procedures relating to children in residential centres, however, Tusla had not reviewed a large number of these policies for a considerable amount of time to ensure they were in line with good practice.

Not all management systems were effective. There were good communication systems between the staff and the centre manager. Staff and the centre manager attended a handover meeting at the start of each shift in order to keep staff informed of what occurred on the previous shift. There was a shift planner which identified staff responsible for completing various tasks. Inspectors observed staff completing tasks assigned to them. There was also a communication book in which the staff and the centre manager used to identify tasks and activities for the day. A diary was used to remind the staff team of important dates and appointments.

There was effective communication at staff team meetings. Meetings were held weekly and standing items on the agenda for team meetings included young people, feedback from the significant events review group, training and risk. Inspectors found that previous minutes were reviewed at the next team meeting. Staff told inspectors that team meetings were consistent, well structured and informative. However, records of team meetings did not always identify specific tasks, persons responsible and timelines for actions to be completed. As a result, it was not evident how the centre manager held staff accountable for actions. The centre manager also attended the regional management team meetings with the alternative care manager on a bi-monthly basis.

Risk was not effectively managed within the centre.There was a revised risk management policy. However, staff had not received training in risk management. The

centre manager advised that they were awaiting new risk management assessment templates in order to implement the new risk management policy. The regional risk register on file in the centre was out-of-date. There was also a risk register which identified risks specific to this centre. However, inspectors found that this register was not consistently updated, review dates had passed and not all risks had been identified on the register.

Risk assessments were used to outline how the risk was to be managed by the staff team. However, inspectors found that these assessments were not completed in full, did not indicate risk ratings and had not been reviewed in a timely way. In addition, some risks in the centre had not been identified on the risk register or had not been reviewed. For example, inspectors found that door alarms were present on each of the young adults bedroom doors, but there were no risk assessments undertaken to support the consistent use of this measure for those living in the centre.

Staff were recruited in accordance with the legislation, standards and policies. However, staff files did not contain the necessary documentation. For example, job descriptions, evidence of probation period, contracts and qualifications were not on files. This issue was identified at the time of the last HIQA inspection. Following this inspection, HIQA requested and received assurances from the alternative care manager that all staff had the necessary An Garda Síochána Vetting.

There was appropriate skill mix on the staff team. However, there were five staff vacancies.There were nine permanent staff and three agency staff on the team in order to fill staff vacancies and support the care needs of young people. Inspectors reviewed the staff roster and found that the agency staff used were regular and were familiar with the young people in the centre. An induction was provided to new staff members.

Staff were not supervised appropriately. Inspectors reviewed supervision files and found that while supervision schedules were in place, supervision was sporadic and did not occur in line with timelines specified in the supervision policy. While staff told inspectors that they felt supported by management, this support was provided informally. On review of supervision which was held, inspectors found that records were brief and there was not always actions or timelines identified in supervision. As a result, records did not indicate that staff were held accountable. While these deficits had been identified by the alternative care manager in a supervision audit in April 2017, these deficits had not been addressed at the time of this inspection.

The centre manager received supervision from the alternative care manager. However, the centre manager did not have a copy of her supervision available in the centre. Following the inspection, the alternative care manager provided inspectors with a copy of supervision notes. On review of these notes, inspectors found that supervision had not been provided in a number of months. Records of supervision were brief and actions were not always identified. Inspectors also found that deficits identified in oversight visits and audits had not been addressed. While the centre manager told inspectors that she was in contact with the alternative care manager weekly and felt supported by this informal mechanism of communication, this was not sufficient to ensure gaps were addressed.

Not all staff had up-to-date training. One member of staff had not received the up-to-

date training in Children First. Three members of staff had not received up-to-date fire safety training. The centre manager completed a training needs analysis in December 2017, which identified these training needs, however this needs analysis did not identify risk assessment as a learning need for the staff team.

Oversight and governance of the service was not effective to ensure the service provided was safe and appropriate. There were some oversight mechanisms in place, for example, a governance reporting tool, two audits and oversight visits had been conducted and an external significant event review group (SERG) who had oversight of the significant events within the centre. However, these oversight mechanisms were not effective as gaps identified were not addressed.The action plans from two oversight visits were not available in the centre at the time of inspection and were subsequently provided by the alternative care manager. Inspectors reviewed a supervision audit which was conducted in April 2017. While deficits had been identified in this audit, actions had not been implemented to address these deficits and there was lack of oversight of the implementation of these actions. The centre governance reporting tool which identified for example, staff training, and centre risks had not been completed by the centre manager in several months. This deficit had also been identified by a monitoring visit completed in July 2017, however action had not been taken to address this deficit at the time of this inspection.

There were clear financial management systems in place. The alternative care manager and the centre manager had oversight of expenditure. A number of staff members held procurement cards for routine expenditure for example grocery shopping. Non routine expenditure was approved by the centre manager. The staff team kept records of expenditure and invoices which were sent to the alternative care manager on a monthly basis for oversight.

Records were stored securely in lockable cabinets.

Judgment: Non Compliant - Moderate

Standard 3: Monitoring
The Health Service Executive, for the purpose of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the Health Service Executive to monitor statutory and non-statutory children's residential centres.

Inspection Findings
The most recent monitoring visit to the centre was in July 2017. The report was available in the centre and made 11 recommendations. The majority of these actions related to the care of young people which did not form part of this focussed inspection. However, inspectors found that two deficits in relation to governance were also identified on this HIQA inspection. Actions identified by the management team to address those deficits had not been implemented within the identified timeframe.

Judgment: Compliant

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Action Plan

This Action Plan has been completed by the Provider and the Authority has not made any amendments to the returned Action Plan.

Action Plan ID:	MON-0021546-AP
Provider's response to Inspection Report No:	MON-0021546
Centre Type:	Children's Residential Centre
Service Area:	CFA DNE CRC
Date of inspection:	21 March 2018
Date of response:	04 May 2018

These requirements set out the actions that should be taken to meet the National Standards for Children's Residential Services.

Theme 2: Safe & Effective Care **Standard 10: Premises and Safety** **Judgment: Non-Compliant - Moderate**
The Provider is failing to comply with a regulatory requirement in the following respect: There were some delays in responding to maintenance requests. Records of maintenance were not up-to-date or complete. Health and safety audits were not consistently completed. Not all staff had received up-to-date fire training. Not all staff had completed a fire drill. **Action Required:** Under Standard 10: Premises and Safety you are required to ensure that: The premises are suitable for the residential care of young people and their use is in

keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care (Placement of Children in Residential Care) Regulations, 1995.

Please state the actions you have taken or are planning to take:

• An audit of maintenance issues was conducted and the maintenance record updated. Any outstanding issues have been reported to maintenance. Where this is a delay in getting requests responded to by the maintenance department, the centre manager will raise the issue with the maintenance department. If the issue is not resolved within 14 days the matter will be escalated by the Centre Manager to the Alternative Care Manager, who in turn will raise the issue with the Maintenance Manager

• A schedule of dates for the year has been put in place to ensure that Health and safety audits are completed within the monthly time frame.

• The three staff requiring training attended fire training on the 24th March 2018. All staff have now received up-to-date fire training.

• As of the 27th April 2018 all staff members and regular agency staff have participated in a fire drill. The Social Care Manager will ensure that all staff and agency staff partake in regular fire drills , as per policy

Proposed timescale: **06/05/2018**	**Person responsible:** **Centre Manager**

Theme 4: Leadership, Governance & Management
Standard 2: Management and Staffing
Judgment: Non-Compliant - Moderate

The Provider is failing to comply with a regulatory requirement in the following respect:

Oversight and governance of the centre were not effective.

Staff did not receive regular and formal supervision.

Records of supervision required improvement.

Risk management systems were not clear.

Not all risks were identified on the risk register.

Not all staff had up-to-date mandatory training.

Staff files were not complete.

There were no policies and procedures to reflect the service provided.

Policies and procedures which guided the staff team had not been reviewed in a considerable period of time.

Action Required:
Under Standard 2: Management and Staffing you are required to ensure that:
The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

Please state the actions you have taken or are planning to take:
• The Social Care Manager of the centre provides oversight on systems. She oversees the completion of young persons plans, daily plans, staff meetings, young people meetings, supervision and internal audits on a regular basis. This is recorded on the young persons logs and paperwork. There are structures in place to support this. The Alternative Care Manager (ACM) is responsible for the external oversight of the centre. To this end there is a schedule in place for (ACM) centre visits and Social Care Manager supervision. The ACM will visit the centre on a bi-monthly basis and as part of those visits will conduct audits of existing systems and will read and sign documentation. The ACM reports to the Regional Manager who supervises her and is responsible for the overall governance of the centres in his region. In addition to this the Regional Manager holds monthly regional meetings with his full management team. The centre governance reports will be brought up-to-date by 30th May 2018 and will be completed monthly thereafter

• Staff meeting records will ensure that all identified tasks, persons responsible and time frames are clearly recorded.

• The Alternative Care Manager will conduct a supervision audit and will address any deficits.
• There is a schedule in place for the Alternative Care Manager oversight visits to the centre. A clear record of what was audited during these visits and actions arising will be provided to the centre manager. Time frames are set for follow up on any actions arising and for a review of these actions by the Alternative Care Manager.

• A new audit tool, which can be used by the Alternative Care Manager and the Centre Manager, will be in place by 31st July 2018.

• Supervision will now be provided by the Social Care Manager, Deputy Social Care Manager and Social Care Leaders. A schedule of supervision is now in place to ensure that supervision is provided as per policy. The Alternative Care Manager carries out supervision audits twice annually. There will be set time frames for follow up on any actions arising and a set time frame for a review of these actions by the Alternative Care Manager.

• A record summarising the main points discussed in supervision will be maintained by the supervisor. There will be a clear indication of who is responsible for actions to be undertaken, with specified time-scales as appropriate.

• The Alternative Care Manager will provide a workshop to the staff team regarding Tusla risk management systems and how they should operate within the centre. This workshop will be delivered by 31st May 2018. Risk management will be reviewed at

team meetings and during supervision to ensure that all staff are clear on the processes involved and supported in the management of risk within the centre.

• The Social Care Manager, in conjunction with the Alternative Care Manager, is undertaking a review of risks in the centre to ensure that all risks have been identified and placed on the risk register. The Social Care Manager will ensure that all risks are reviewed and updated monthly.

• The centre manager will liaise with workforce development to ensure that staff receive all mandatory training by 31st August 2018

• All staff files are now complete.

• The process of developing a new national suite of Policies and Procedures for CRS is currently underway. This process is due to be concluded by end October 2018. In the interim that social care manager will continue to operate off the current policies and procedures for Dublin North East. In Addition, the Alternative Care Manager and Social Care Manager will create guidance where appropriate to address the needs of the young adults in our service. This guidance will be completed by mid June 2018.

Proposed timescale: **31/10/2018**	**Person responsible:** **Alternative Care Manager**