An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 022

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Fresh Start Ltd**
Registered Capacity:	**Four**
Type of Inspection:	**Announced**
Date of inspection:	**05th, 06th & 10th February 2020**
Registration Status:	**Registered without conditions 6th of October 2017 to the 6th of October 2020.**
Inspection Team:	**Eileen Woods** **Ruth Coakley**
Date Report Issued:	**6th May 2020**

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 Assurance 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 6th of October 2014. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from the 6th of October 2017 to the 6th of October 2020.

The centre was registered to provide care for four young people aged between thirteen to seventeen, with placements being on a medium to long term basis. The model of care was a needs led therapeutic care model for children and young people with a history of trauma, separation and loss. There were four young people living in the centre at the time of the inspection. Two of those young people were children under the stated age range and exemptions to the registered purpose and function were granted for their placements.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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, and centre manager on the 14th of April 2020 and to the relevant social work departments on the 14th of April 2020. 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 24th of April 2020. This was deemed to be satisfactory and the inspection service received evidence of the issue 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: 022 without attached conditions from the 6th of October 2017 to the 6th of October 2020 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The registered proprietor of this centre had taken evidenced steps, with their senior management team, toward compliance with the relevant policies as outlined in the relevant legislation. This was demonstrated through the provision of policies and procedures updated in line with the Children First Act 2015 and Children First: National Guidance for the Protection and Welfare of Children 2017. Feedback from other inspections within the wider company had been acted upon without delay and the policies updated and re-circulated to staff. At the time of this inspection the registered proprietor outlined that they had commissioned and commenced the creation of a bespoke policy review and quality assurance system in line with the relevant legislation, regulations and national policies and standards. The registered proprietor had already begun the internal process of review their policies to ensure that they met requirements of the National Standards for Children's Residential Centres 2018 (HIQA).

The policies and procedures outlined the forms of abuse and neglect that can occur and how to respond. There was an anti bullying policy and procedure in place, this addressed the actions in place to prevent bullying and the responses to it should it occur. The anti bullying policy had been expanded to include cyber bullying as well as online safety awareness and inspectors found that staff were knowledgeable in the in their practice in this regard. Online and internet safe usage was a live issue at the centre and the team required further support from external management and the social work department to collaborate on the best approach to one young person's care.

The suite of policies in place outlined safeguarding procedures for staff to protect and support children and young people at risk. There were polices on online safety, anti bullying, safeguarding and child protection. The staff displayed good knowledge during interviews of the procedures to complete in line with the relevant policy should they need to make a child protection report. They identified the company appointed designated liaison person, DLP, who they could seek advice and support from and what their reporting responsibilities were if they were a mandated person.

The team had completed the Tusla E learning module: Introduction to Children First. The company had additional complimentary training child protection and safeguarding training for staff. Training records indicated that both training modules had either been completed, were booked for new staff or were due for renewal and booked for existing staff. Inspectors were informed by staff that the training included safeguarding and the prevention, detection and response to abuse.

Inspectors found that the staff team did work in a safety and safeguarding informed framework, this was evident at their handovers, team meetings and in supervision. They had agreements in place for the social workers to relay important information including if any incidents or allegations of abuse occurred to families in line with the legal arrangements in place. The social worker who was interviewed, who represented three of the four young people, was happy with the standard of communication related to safety and well being and had regular visits and communication with the centre and young people

The inspectors found evidence of key working and of opportunity led work on building self confidence and growth in self care and self protection for the children and young people appropriate to their age and circumstances. The files for the young people contained records of their areas of vulnerability and how individually these were addressed with them, the records evidenced that staff acted on the plans in place. The voice of the young people was well recorded in the direct work and in their comments day to day as recorded in their daily logs. Inspectors heard from the young people and they indicated that staff did work to try to keep them safe. Individually they had questions for their social workers about the length of their placements relevant to their age range. The social worker interviewed was aware of these questions.

There was a new policy in place on protected disclosures and staff were aware of it and had discussed its content and its purpose. The team were knowledgeable about the external management structure of the company and who to report a protected disclosure to if required.

Standard 3.2

Inspectors found evidence of positive behaviour support integrated throughout the systems and policies for the centre. This was evident through supervision, team meetings, the key working meetings and plans for young people. Handovers also supported this process as did the placement plan evaluation system. The staff team

named that the manager and deputy directed their work and provided guidance on interventions and supports. The multi disciplinary team meeting records displayed discussion around the therapeutic approach and advised the team on how to support the young people. There was evidence in rates of significant events, school attendance of positive on-going outcomes in specific areas of their lives. The team reported some positives achievements through the incident reporting system. The staff team identified to inspectors that to enhance their work they required training on intellectual disability. The operations manager outlined that specific training modules can be requested and would be provided internally by the company.

The staff team were trained in a recognised model of behaviour management and implemented the support tools from this in practice at the centre. There were plans on file for the young people that, with the advice of the clinical team, addressed their emotional needs and were aware of their individual experience of trauma, separation and loss and how these affect young people. The needs of the group were diverse and the team were found by the inspectors to work hard to comfort, care for and support them in accordance with their age and needs. The team sought additional advice and guidance where needs changed. A social worker said that they were happy with the standard of care and supports being provided to the young people, that their rights were taken account of as well as their emotional, physical, education and psychological needs.

The young people told inspectors a little bit about how they had been supported to gain an understanding of the care and support available to them from the team. Inspectors found that relevant to their age and ability they were able to name how some of this had benefited them in understanding challenging behaviour. The young people named that they were supported to ask questions about why things were happening around, for example, certain rules or types of key work being completed with them. The records showed that they was active work taking place to support the young people in a positive manner that took account of the underlying causes of behaviours that challenge. The young people and the staff could access the advice and support of the clinical team, the management and their social worker or guardian.

There had been pre admission processes completed for all four young people and the information had been made available to the relevant parties. The centre's planning integrated this information and utilised it to create client profiles, risk assessment and management plans and placement plans. The registered proprietor had in place

a quality assurance and practice manager and an operations manager who alongside the clinical manager/DLP co-ordinated an oversight mechanism for the centre.

The registered proprietor met with inspectors and outlined that in the senior management meetings and company managers meetings that they track all reported and audited aspects of the service. They had up to date information regarding this centre including the impact of the model of care in bringing about tangible and measureable improvements for young people's lives. Inspectors found that the records maintained of those management meetings supported that. The proprietor outlined that they were aware that an expanded quality assurance and auditing system was required for consistency and clear records and they have commissioned such a system to be created for the company. This was an ongoing process at the time of the inspection.

Inspectors found that the model of positive behaviour support had been the subject of an initial internal audit in January 2020, the manager had been supplied with the report which was generally positive with some areas identified for action. There was evidence at the centre that these were being acted upon, for example, reporting of positives and staff knowledge of new and updated policies. The January 2020 internal audit was the first to take place against the National Standards for Children's Residential Centres 2018 (HIQA).

The centre manager had introduced, in January 2020, a restrictive practice register and a restrictive practices procedure had been implemented recently by the company. This had been circulated to all staff. There were no restraints undertaken at the centre in 2019 or in 2020. Inspectors observed that there was a restrictive practice in place in the centre that resulted in the kitchen area being locked nightly. Inspectors discussed this with the management and also discussed the buzzers in place in the bedroom area which were in place as a required safeguarding tool. The management committed to reviewing and including items that meet the criteria for restrictive practice on their records and to stop implementing practices where not proven to be required.

Standard 3.3

Inspectors found that the children and young people had been provided with information regarding their placement, how to raise concerns and what their rights were. They had been introduced to the senior people in the management team when they moved in. They were given information about the company's complaints

procedures and about Tusla's complaints procedure 'Tell Us'. The young people opted not to have this information displayed at the house and there were house meetings and one to ones with staff as well as key working sessions where their views were recorded. The young people told inspectors that sometimes things changed when they raised a matter that concerned them but that staff always came back to them to explain the reasons why. Staff received regular supervision and were supported to raise issues and address them directly with each other, at team meetings or handovers if suitable. Concerns raised that could not be addressed directly between staff were dealt with by the manager and where appropriate supported by senior management. A social worker outlined that they were happy with the nature of the consultation with the young people under their care and that where they were not hearing directly from the young people that staff or the guardian ad litem brought issues to their attention.

Inspectors found that feedback from staff was channelled through team meetings and supervisions and brought to senior managers. There was discussion of young people's complaints up to proprietor level. Inspectors were informed that a direct mechanism for the voice of the young people was being included in the revised quality assurance systems. Feedback from families and professionals must also be included as part of the newly commissioned governance system being developed.

Three of the young people had a guardian ad litem to visit on a monthly basis, EPIC the children in care advocacy service had visited and there was evidence of contact with their social workers captured on the centre records. There were specific agreements in place around family contact and there was evidence of comments from parents being recorded and notified on occasion to senior management.

There was evidence of collaborative work with the social workers but less so with families due to the specific circumstances. The areas that were to be reported to families directly by the centre were decided in agreement with the social workers. It was the social work departments responsibility under these agreements to report any complaints, concerns or allegations of abuse should they occur.

There was a suitable policy in place regarding incidents and the procedure from this policy was reflected in practice, the policy was updated in 2019. Inspectors found that the team reported significant events effectively and efficiently to the relevant parties including verbally to the relevant involved parents and significant others. The manager and their deputy manager had oversight of all significant events and follow up actions. It was evident from team meetings and supervisions as well as debriefs

that learning was taken from events. It was also evident that there was follow up throughout with the young people involved to ensure they were fully supported.

The manager and the deputy manager completed an internal monthly incident monitoring form and there was monthly senior team review of serious incident that met a threshold for severity. There was follow through, after these reviews, in practices at the centre in a manner that benefited the young people.

The senior team meeting minutes confirmed that serious incidents, their outcomes and actions in response were discussed. The multi- disciplinary team contributed to the teams tracking of patterns of behaviours and how to interpret and respond to these. Incident reviews involved the clinical manager/DLP who was also involved in all complaints as well as all child protection matters. They had communicated directly with the manager regarding observations around implementing agreed responses and their outcomes.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.1** **Standard 3.2**
Practices met the required standard in some respects only	**Standard 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- The registered proprietor must ensure that they develope and implement a formal mechanism for feedback from parents, social workers and significant others in the young people's lives.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The registered proprietor provided evidence of their existing systems for oversight and governance of the centre's compliance with the requirements of the standards, regulation and relevant legislation. They along with their senior team including a clinical manager, an operations manager and a quality assurance and practice manager work together with the centre management to track and review practices inclusive of all child protection matters, serious incidents and complaints.

The proprietor provided evidence of actions being implemented to introduce the National Standards for Children's Residential Centres, 2018 (HIQA) to the team and to reflect the national standards, relevant legislation and national policies in their policy document.

The proprietor has commenced the process for acquiring a new quality assurance and governance system geared to the new standards and legislation which would increase their capacity to generate reports identifying any gaps in compliance and areas that would benefit for further development.

The staff at the centre demonstrated to inspectors that they had a good understanding of safeguarding and child protection, of the new standards and how their policies were expanding to reflect the new standards. Their key working and day to day work evidenced an understanding, supported by the clinical team, of the needs of the young people and their individual role in delivering good quality care for children.

Standard 5.2

The inspectors found a stable management structure in place within the centre with clearly defined roles and leadership displayed by the manager and supported by the deputy manager. The manager, who is the named person in charge, was experienced in their role and displayed a child centred approach to the care and welfare of the children and young people. This was a centre with a large team and the manager and their deputy divided tasks in a clear and recorded manner designed to assist the team in the daily running of the centre. They attended team meetings, clinical meetings,

completed supervision and support sessions with staff and communicated effectively with external persons. The manager facilitated internal review of the daily work and implemented a safe care approach to practice. There was evidence of their and the deputy managers oversight of all records and all planning documents including those related to risk assessment and management. The team provided feedback that the management were decisive and supportive in their role.

The company provided a training schedule for staff, there was monthly access to a clinical team for advice and learning and there were risk management and health and safety systems operational at the centre.
External governance were informed through monthly reports and checklists provided to their operations manager by the centre manager. They also reported to the clinical manager and the quality assurance and practice manager in the areas relevant to their respective roles. There were weekly management checklists and systems for accountability and responsibility for the daily running of the centre. The manager oversaw the responses to all internal audits, internal queries from the clinical team and from the operations manager. They met with the senior team including the proprietor on a monthly basis. They were supervised in line with policy timeframes by the clinical manager. The manager and the deputy met in supervision and held internal management meetings regarding the general operation of the centre and their respective tasks.

The director and the management team outlined that although there were three different reporting streams from the centre that due to their co-location as an external management team that all information from the centre was co-ordinated and responded to by them. Inspectors did not find this as easily traceable at centre level and advise that as part of their governance and compliance project that they consider this and analyse any gaps that may occur. The existing governance arrangements for the company and the centre were well known by the team.

The centre had a contract in place with the funding body Tusla, the Child and Family Agency. The proprietor reported to the funding body, is regulated by the funding body and had annual meetings regarding their contracts and compliance with the obligations therein.

The manager was the designated person in charge for the centre and inspectors found that they were aware of this designation and its stated responsibilities as outlined in the National Standards for Children's Residential Centre 2018 (HIQA) and the relevant regulations.

There were a full set of operational policies and procedures available at the centre. There had been policy reviews in July 2019, December 2019 and in January 2020, the senior team responded to the immediate changes or additions required to bring the policies in line with the specific relevant standards and legislation. The proprietor and senior managers outlined that this will remain a live process until the full roll out of the standards and of the compliance and governance system when it is completed, they had not as yet identified a completion date for this.

Staff members in their written and verbal contributions to this inspection demonstrated their working knowledge of their specific roles and responsibilities. These were set out in writing in their job descriptions, in supervision, team meetings and contracts. The staff team rotated lead roles for example in health and safety and provided formal mentorship from experienced staff trained as mentors to new staff members. They attended the training identified for them, asked for complementary training and contributed well to the overall running of the centre. There was evidence of good quality key working and of advocacy for the young people.

There was a risk management framework in operation at the centre and this included a risk register which was reviewed on a monthly basis. There were risk management plans in place these were the subject of review as advised by the clinical team.

There were adequate numbers of staff in place for the numbers of young people and the nature of their needs. The arrangements for acting up as the person in charge were part of the named duties of the deputy manager, in the event that neither would be available a contingency plan would be the responsibility of the operations manager.

Standard 5.3

A copy of the centres statement of purpose and function, which was updated in November 2019, was provided to inspectors. The review of the statement of purpose was part of the centres on-going implementation of the National Standards for Children's Residential Centres 2018 (HIQA) and the version provided was a clear and accurate document that was developed against the specific criteria.

The type of service, its aims, therapeutic model of care and staffing arrangements were clearly outlined. The needs led aspect of the model was described alongside the how this would support good quality of life and care goals of the centre.

Inspectors found that the statement of purpose and function was reflective of the day to day practices at the centre. The staff team were knowledgeable about the model and outlined how this translated into daily caring approach that was attentive to the children and young people's emotional and social needs.

The inspectors found that the statement was displayed at the centre for the staff, there had not yet been an arrangement to circulate this document to other professionals and families. The document was though circulated to social workers on the 6th of February 2020. The company has neared completion of a review of its parent booklet and this outlined the shared company model of care. There were separate leaflets for social workers and other professionals which did the same.

All professionals involved in sourcing a placement at the centre were provided with information regarding the work undertaken there. The proprietor outlined that a formal system for seeking and including feedback from parents, guardians and significant persons was part of the upcoming development planned for the service.

Standard 5.4

As outlined earlier Inspectors did find evidence, reinforced by access to the proprietor's records, of a system of oversight. The system was intended to reflect on quality, compliance and welfare of children within this centre and the company. There were senior persons in defined posts who were experienced and had established work practices in place related to their relevant areas of clinical, operational and quality assurance. The proprietor outlined that they were commissioning a governance and oversight system.

The manager and their deputy received written feedback from the operations and quality assurance manager on the adequacy of their responses and reporting to management. The manager had maintained their management records well, all were clear, signed and completed in accordance with their relevant internal timeframes. The internal governance systems at the centre were geared to purpose and were supportive of improvements in practice. The placement plan evaluations completed by the staff team were a particular example of measureable review of interventions and their outcomes specific to each child's needs. The clinical team and the clinical manager provide insight, advice and oversight of these also.

Inspectors found that the proprietor had a system and personnel in place to ensure that information in relation to complaints and serious concerns were formally

brought to their attention. Records evidenced that matters of this nature when reported to the proprietor were reviewed for action, advice provided and learning promoted. There was evidence at centre level of discussion and review at multidisciplinary and team meetings. Changes and improvements were observed on occasion across centre records. The bimonthly placement reports for social workers but did not as routine contain all informal and formal complaints and should for the purposes of tracking and review.

An annual review of compliance with the centre's objectives was not yet conducted by the organisation and the registered proprietor was aware of their obligations in this respect.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.2** **Regulation 6.1**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 5.1** **Standard 5.2** **Standard 5.3** **Standard 5.4**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**None identified**

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered proprietor must ensure that they develope and implement a formal mechanism for feedback from parents, social workers and significant others in the young people's lives.	An updated feedback form has been developed and has been shared with the Social Work Departments and families on 23.04.20.	The Centre Manager will ensure an updated feedback form will be shared with Social Workers and families for all future referrals to the centre.
5	None identified		