An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 129

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Terraglen Residential Services Ltd**
Registered Capacity:	**Three**
Type of Inspection:	**Announced Themed**
Date of inspection:	**15th & 16th of July 2020**
Registration Status:	**Registered without attached conditions from 16th August 2020 to 16th August 2023**
Inspection Team:	**Eileen Woods** **Linda McGuinness**
Date Report Issued:	**11th August 2020**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 16th of August 2017. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from the 16th of August 2017 to the 16th of August 2020.

The centre was registered to provide care for three young people aged thirteen to eighteen years on a medium to long term basis. The model of care was described as relationship based adapted from pro-social modelling and attachment theory. There were three children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
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 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. Due to the emergence of Covid-19 this review inspection was carried out remotely. This inspection was carried out through a review of documentation and a number of telephone interviews.

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 centre manager, service director and the relevant social work departments on the 31st July 2020. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 06th August 2020 and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the 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: 129 without attached conditions from 16th August 2020 to 16th August 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulations 5: Care Practices and Operational Policies
Regulation and 6 (1 and 2): Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The directors of the service had updated the centres policies and procedures in line with the National Standards for Children's Residential Centres, 2018 (HIQA) and with reference to relevant legislation and guidelines. The staff had received induction into the main policy document upon commencement with the company and thereafter when a new policy was added or one updated to reflect necessary changes. The centre management stated that where they identified a need that they had reviewed additional policies at team meetings. Inspectors found that staff demonstrated knowledge of a range of specific working policies and procedures in the returned questionnaires and during interview.

Inspectors found that the reviewed policy document was extensive and structured in line with the national standards. The senior management team had a plan in place to deliver training and induction into these once printed. The staff team provided some evidence that they were working in accordance with the existing policies and had good overall knowledge of the core procedures most relevant to their day to day work, for example the risk assessment and management procedures, key working and placement planning. Inspectors did find that there were specific areas requiring further focus with the team and these included restrictive practices, protected disclosures and the procedure for the processing and recording of all types of complaints. Inspectors recommended to the management that they include a focus on these policies over coming weeks and they agreed to same.

During the first months of the pandemic response the management at the centre reviewed policies in supervision sessions when remote team meeting arrangements made it more difficult to do so effectively at team meetings. There was evidence that some policy compliance was tracked and referenced at the centres internal senior team meeting and in the weekly governance reports to the external management.

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-cantered, safe and effective care and support.

In March 2020 an acting manager was appointed to the centre for a defined period of time. The person had previous experience at a senior level. They received an induction and support from the outgoing manager. Documents reviewed by inspectors covered the period of the manager's work and the acting manager's initial work. The manager role was supported by a deputy manager and inspectors found that a culture of well organised placement planning for young people was maintained in place. There were training schedules and regular team meetings focused on learning and development. The social workers for two of the three young people and the parents all noted positives with their young person. Inspectors received positive feedback from two of the young people who responded also. Through challenging times they all noted that leadership in planning and decision making for safety and best practice was evident to them at the centre.

Inspectors found evidence that there was a clear management structure in place, roles were identified and staff demonstrated clear knowledge of each person's professional role and responsibilities within the senior level of the organisational structure of the company. Inspectors found evidence of a culture of continuous improvement and development of staff skills. There was a list of delegated tasks created and these listed those of the social care leaders only. Inspectors recommend that the delegated tasks list be reflective of the key delegated tasks for the deputy manager. There was a senior internal team meeting on a monthly basis and the records of these outlined the key decisions made. The inspectors found that the management should review the balance of management roles at the centre and the purpose of each as there was evidence that experienced senior staff were potentially being subsumed into management roles which was not the intended outcome of the structures in place.

Inspectors found that accountability at the centre was promoted through shift evaluations, reflective practice, debriefing, handovers and team meetings. There was also evidence of regular supervision and case management meetings for key work and placement planning. At senior level this was captured through the weekly governance reports, the bi monthly audits, management meetings and communications between the senior managers. The centre had policies on leadership

and management, clinical governance and internal auditing procedures and inspectors found that structures and work practices were in place in line with the policies. The policies were appropriate to the governance requirements of the centres purpose and function.

The centre had a previously agreed contract with Tusla for the provision of a service as identified in the agreed statement of purpose. The tendering process was ongoing by Tusla and the centre was part of the process.

The centre had a risk assessment and management policy in place and the inspectors found that the staff had been inducted into the policy. Inspectors confirmed that staff were implementing it in practice and this was overseen by the management at centre level through document review, register review and discussion at team meeting and significant event review group meetings. These had also been reviewed through the external auditing process and found to be substantially compliant. The policy included a procedure for escalation externally should that be identified as required. The policy linked to how, procedurally, risk assessment at centre level would inform other behaviour management options and plans for young people. The centre had a range of risk registers, these included the dynamic risk assessment register that individually advised the behaviour management approach with the young people, an environmental risk register, an organisational risk register and a staff risk register. There was evidence of oversight and governance of these registers and they had been audited internally and externally at the time of this inspection visit.

The company had a dynamic 'interim health and infection prevention control information, guidelines and procedures on the prevention and management of Covid 19' document. During all stages of the national response to the Covid 19 pandemic the directors had made staff aware of the arrangements and changes in place. There were Covid 19 related risk assessments and risk management plans for each young person, for staff daily work and the premises. Short term response actions such as manager off site work and longer shifts on the roster to reduce footfall were removed without undue delay. The team were supported through team meetings, supervision and supplementary supervision; they were also advised of the availability of the organisations employee assistance programme.

The manager maintained a list of assigned persons rostered to provide an on-call system, this was shared between the manager, deputy and the three social care

leaders. The directors were available as senior on call taking account of the additional needs around the ongoing pandemic response.

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

Inspectors reviewed a copy of the statement of purpose for the centre and found that it had been updated in the preceding six months; it was signed by the CEO, the director of services and the full time manager. The external audits confirmed that the updated copy was displayed in the centre and circulated to the professionals involved. The parents told inspectors that they received information about the centre and had good insight into the model of care there. In response to this inspection two of the young people identified that this was their home until they left care and they along with their parents outlined the type of "trustful and respectful" relationships as named on the statement of purpose as a goal.

Inspectors found that the statement of purpose was developed in line with the criteria as laid out in the national standards and had been reviewed and evaluated through the external quality assurance and auditing systems. The directors had in place a quality improvement plan operational from March 2020 which identified ongoing development within the company. The numbers of staff were suitable to the operation of the centre in line with its aims and objectives. The team were trained in the model of care and additional clinical support and guidance was being introduced by the company.

The team referenced during their interviews and in their questionnaires the intended model of pro social modelling and gave concrete examples of how they implemented this day to day. A key component of the model of care was the use of rewards and incentives, the deputy manager confirmed that this approach does not extend into the preparation for leaving care phase of a young person's placement.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

The centre generated a weekly governance report, internally overseen by the manager and sent to the director of operations who responded to the report with any observations, questions and tasks within three days. The director of operations, pre pandemic, quality assured the weekly reports through announced and unannounced

visits to the centre, participation in significant event review, review of the risk assessment framework and team feedback. During the pandemic the weekly reports and response was kept in place and contact continued remotely. The directors jointly conducted quality assurance audits against selected themes from the National Standards for Children's Residential Centres, 2018 (HIQA), relevant regulations and statutory requirements. The policy for external audits set the regularity at bi monthly and this had been disrupted temporarily by the initial pandemic response. The gap was short with an audit in February 2020 and the next taking place at the end of June 2020. Once an external audit was completed required actions were identified within it and inspectors saw evidence of these being responded to by the manager and acted on within a set timeframe.

An emergency strategy was implemented to adapt oversight during the pandemic utilising digital communication for meetings and oversight. The safety of staff and young people was given due regard through the creation and circulation of general guidelines and procedures for managing Covid 19 and ensuring that all staff availed of relevant national training provided by the HSE for frontline workers.

Inspectors found that the staff had a focus on outcomes for young people and that the reviewed policies and procedures further supported this outlook. The centre staff, some of the social workers, young people and parents identified to inspector's areas of ease and safety in their daily lives taking account of their personnel circumstances. Inspectors found that there was evidence of a renewed focus on planning and assessment with another social work department evidencing flexibility for continuous review and improvements in the quality and safety of care provided to the young people.

Inspectors identified a gap in the implementation of the complaints policy and procedure regarding the recording and tracking of informal internal complaints. The policy outlined that these must be recorded on the centre register to allow for accurate analysis and monitoring by the external management. This was not how the policy was interpreted at the centre and the team outlined that the records of these would be displayed in the centres daily logs. Inspectors could not examine the daily logs or all the individual works remotely but did establish that there were no formal complaints recorded in the complaints register for the preceding twelve months. There was no evidence of discussion or resolution of dissatisfactions in the samples of young people's meetings, team meetings, mangers meeting or audits. The weekly governance reports did have a section for complaints but these contained no records of any complaints in the samples reviewed.

The tracking of concerns and review of incidents was clear throughout the significant review group, strategy meetings, professionals meetings and child in care reviews. The parents and social workers stated that they were kept informed of all concerns formally in writing and followed up through phone calls and visits.

The external management audit systems had not as structured assisted them to identify gaps in how the centre interpreted and implemented the complaints policy and procedure and they should evaluate this as part of their quality improvement plan. They agreed that they were aware of the anomaly in recording approach and would address this. Inspectors did not find evidence of serious complaints that were not notified but did hear about internal dissatisfactions that the team had managed with the young people that should be tracked in accordance with the intended approach.

The directors had implemented a quality improvement plan from which an annual review of compliance will be drawn. The plan had been reviewed by the Board of Management and the framework was robust, reviewed and included accountability for identified actions. The plan was informed by the weekly governance reports, self evaluations checklist and internal audits. The annual report process will run from April to April with 2021 being the first report.

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

Actions required

- The acting manager must create a list of delegated tasks for the deputy manager.
- The complaints policy and procedure must be formally revised with the staff and the intended recording approach implemented.
- The acting manager and deputy must review the records, talk to young people and the staff to satisfy themselves that all areas on dissatisfaction or formal complaint had been satisfactorily acted upon.
- The external management should evaluate their auditing practices to ensure that they support good gap analysis.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The acting manager must create a list of delegated tasks for the deputy manager.	Acting Manager has created a list of delegated tasks for deputy manager.	List of delegated tasks will be monitored in supervision ongoing with DSCM.
	The complaints policy and procedure must be formally revised with the staff and the intended recording approach implemented.	Acting Manager has revised the complaints policy and procedures with staff at a Team Meeting and directed all staff to read and sign policy. Acting Manager discussed the recording process of both formal and informal complaints and brought complaints register to the Team Meeting.	Acting Manager will maintain oversight of resident's meetings and all records to ensure that the recording process for both informal and formal complaints is been implemented and documented in the complaints register.
	The acting manager and deputy must review the records, talk to young people and the staff to satisfy themselves that all areas on dissatisfaction or formal complaint had been satisfactorily acted upon.	Acting Manager has closed out on the current complaints and spoken with young people and staff on areas of dissatisfaction to ensure closure and action.	Acting Manager will ensure that all areas of dissatisfaction are addressed in line with complaints policy ongoing.
	The external management should	External Management had picked up on	The root cause of the gap in oversight was

	evaluate their auditing practices to ensure that they support good gap analysis.	the practice regarding complaints processed in audit 002 of internal auditing mechanism. The Auditing process is thematic and will include elements of standard 5 in all themes ongoing to include the complaints process with priority.	compounded by the inability of Directors to attend the centre with COVID-19 restrictions for close out on audits. Directors are completing on-site themed, spot, and scheduled audits as well as remote monitoring through SEN's and Weekly Governance reporting.