An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 041

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Misty Croft Ltd**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced themed inspection**
Date of inspection:	**24th and 25th February 2020**
Registration Status:	**Without attached conditions from the 12th May 2018 to the 12th May 2021**
Inspection Team:	**Cora Kelly** **Ruth Coakley**
Date Report Issued:	**5th May 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 12th May 2009. 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 the 12th May 2018 to the 12th May 2021.

The centre was registered to accommodate separated children seeking asylum from age thirteen to seventeen years on admission, on an emergency, short, medium and respite basis. Their model of care was described as child centred, using a needs led approach. There were six children living in the centre at the time of the inspection.

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, centre manager and to the relevant social work department on the 6th 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 21st April 2020. 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: 041 without attached conditions from the 12th May 2018 to the 12th May 2021 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The centre's child protection policies and procedures were last updated in January 2020. The inspectors found from the review of the document that they were compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015. The centre had an appropriate child safeguarding statement and a letter of compliance to say that this had been reviewed and approved by the Tusla Child Safeguarding Statement Compliance Unit. This statement was available to view in the staff office. The list of mandated persons that was provided to the inspectors was deemed appropriate. Procedures for reporting disclosures and allegations, protected disclosures, lone working, bullying and harassment, complaints, staff professional code of practice and children's rights were contained in the policy document in addition to the definitions of abuse being outlined. So too, were policies and procedures relating to contact with family, contact with friends and electronic communication that included procedures for responding to and managing possible exploitation on the internet and social media.

The role of the designated liaison person (DLP) was held by the centre manager with the deputy centre manager holding the deputy DLP role. Both had been provided with the relevant DLP training. Staff in the centre had received safeguarding training based on the centre's own child protection policies and procedures that included the prevention, detection and response to abuse. Staff had also completed the Tusla E-Learning module: Introduction to Children First, 2017. In interview staff were clear of the safeguarding policies guiding their practice and described the procedures for keeping young people safe including those that related to protected disclosures. This was also stated in staff questionnaires.

It was evident to the inspectors from their review of young people's files, centre records and interviews conducted that staff in the centre worked in partnership with the young people and their allocated social workers to promote the safety and well-being of children. Given the purpose and function of the centre working in partnership with families was not always a possibility. When possible, it was in agreement with the young people's social workers including if parents were to be

informed of any incident or allegation of abuse. All four social workers confirmed this in interview.

At the time of the inspection the centre did not have a standalone child protection register to record child protection and welfare concerns. A register was developed and implemented in the days following the onsite inspection. Since the last inspection a number of child protection and welfare reports had been reported to Tusla through the online portal system. A small number of recently submitted reports were outstanding at the time of the inspection. The inspectors found that overall the reports were promptly investigated and closed. From the review of young people's files and centre records the inspectors found that there was an oversight in reporting practices. It was found that two child protection and welfare concerns were reported to the relevant professionals as significant events process and not as child protection and welfare reports. This was brought to the attention of the centre manager who explained the reasons for not reporting them as such. The centre manager accepted the inspector's findings and the reports were submitted through the appropriate reporting channel after the onsite inspection. The inspectors found that there were no current risks to the young people as a result of the delay in the child protection and welfare reports being submitted as the allocated social workers had been aware of the information contained in the reports.

With the assistance of the separated children seeking asylum social work department young people's high level vulnerabilities were identified through the pre-admission risk assessment and safety plan process. Impact risk assessments for young people resident in the centre were completed when concerns arose during the pre-admission risk assessment. Absence management plans that were developed at the admission stage were revised on a regular basis following a risk assessment process. Individual risk assessments were completed when deemed required by staff and management.

The inspectors found that the young people were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. The centre's key working policy and key working programme guided staff with this. The work completed with the young people was found to have been in line with the statement of purpose and model of care guiding staff practice. The centre manager and staff were very clear of the needs and challenges faced by the young people and had in place supports to meet their needs including the availability of interpreters. Keyworkers were allocated to each young person and work undertaken was found to have been age appropriate, acknowledged their individual circumstances and was completed in a sensitive manner. In interview social workers spoke positively of the safeguarding work conducted with the young people. Young

people were encouraged and supported by management, staff and social workers to speak out if they were feeling unsafe or vulnerable.

Standard 3.2

The centre had policies and procedures for the management of behaviour, managing behaviours of intimidation, aggression and violence, physical interventions, consequences and restrictive practice. Staff had been trained in a recognised model of behaviour management and were provided with regular refresher training. In interview, staff were clear on the procedures for managing behaviours that challenged. This was observed from the inspector's review of staff questionnaires. Staff had a good awareness of how to manage and respond to mental health concerns. Staff in interview explained the procedures for responding to instances of bullying that included completing anti-bullying keyworking sessions with young people. Young people were found to have been informed of their expected behaviours at the initial stage of admission to the centre. This information was also contained in the young person's information booklet.

The inspectors reviewed the centre physical intervention register and found that there had been no entries since the last inspection. Individual crisis management plans and behaviour support plans were found to have been implemented when required and in agreement with social workers. When required, interpreters were sought to facilitate staff in completing individual work with young people including to help them to understand behaviour that challenged. Staff's experience in this area ensured that information was shared with young people in a clear, appropriate and positive way to support their growth and development. Instances of challenging behaviour and follow up individual work with young people were found to have been discussed at team meetings and during supervision.

The positive approach by staff in managing behaviour was evident. Positive behaviour was recognised by staff with young people receiving positive consequences. Negative consequences were minimal but when used were connected to the behaviour presented by the young people and were age-appropriate. This was evident from the review of the centres consequences log, staff questionnaires and interviews.

The director of services had responsibility for oversight of the two types of monthly internal reports completed by the centre manager and the deputy centre manager. Through this governance tool information relating to behaviour management, incidents, complaints and consequences was captured. They were also discussed at the weekly team meetings. The inspectors found that the audit tool in use by the

director of services was not aligned to the National Standards for Children's Residential Centres, 2018 (HIQA). The tool did not reflect fully the monitoring of the behaviour management approach used in practice. The registered provider must ensure that an audit tool that captures the centres approach for managing behaviour that challenges, based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed.

The centre's restrictive practice policy included guiding principles and detailed the individual duties and responsibilities for all staff, the centre manager and senior management when such practices are deemed necessary. There were no ongoing restrictive practices in place in the centre at the time of the inspection. Given the nature of the young people referred to the centre restrictions were naturally placed and removed upon assessment by social workers and were linked to pre-admission risk assessments.

Standard 3.3

The inspectors found that there was an open culture in the centre whereby young people were supported and encouraged to raise concerns and report incidents. Individual keyworkers were allocated to the young people with the process ensuring that the voices of the young people were heard and that the keyworkers would advocate on their behalf. Young people in interview stated that they liked their keyworkers and would talk to them. The voices of the young people were also heard at care plan meetings, development of their placement plans and weekly young people's meetings held in the centre. From the review of supervision records and interviews staff were too supported to raise concerns. The centre manager was found to have been professional and supportive of staff in this regard.

Young people were informed of the complaints policy and procedures verbally upon placement in the centre and during keyworking sessions. Information was contained in the young person's information booklet. The advocacy group, Empowering People in Care (EPIC) had visited the centre and met with the young people. Complaints were discussed at team meetings and included in the internal monthly governance reports. It was found from the inspector's review of the complaints register that the three formal and informal complaints were managed appropriately by the centre in consultation with the relevant social workers and all were concluded.

Mechanisms were in place for the separated children seeking asylum social work department to provide feedback and identify areas for improvement. This was not in place for parents due to the nature of the centre.

The centre had a policy on significant events including the notification of significant events (SEN's). There were internal and external systems in place to review SEN's. All four social workers confirmed in interview that they received notifications promptly and were satisfied with the quality and content contained therein. The inspectors review of the centre's SEN register verified this. Internally, SEN's were reviewed at team meetings and were included in the internal monthly governance reports. Social workers were also informed of incident reviews through progress reports received by the centre. The centre was part of an organisational SEN review committee. There had been a significant time lapse between meetings that were to be held on a bi-monthly basis. The registered provider must ensure that SEN reviews are held in line with policy. From the review of the minutes of such meetings held to date it was evident that significant events were discussed in depth and learning outcomes and decisions were fed-back to staff at team meetings.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The registered provider must ensure that an audit tool that captures the centres approach for managing behaviour that challenges, based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed.
- The registered provider must ensure that SEN reviews are held in line with policy.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The centres policies and procedures, which are subject to two yearly reviews, were last updated in January 2020. It was clear from the inspection process that the centre was operating in compliance with regulations and Children First: National Guidance for the Protection and Welfare of Children, 2017. The managing director and director of services held responsibility for ensuring that the centre was operating in line with the National Standards for Children's Residential Centres, 2018 (HIQA).

The centre manager and staff had good knowledge of the legislation, regulations, policies and standards. It was evident to the inspectors that it was reflected in all aspects of their practice. Staff had a good knowledge of safeguarding practices guiding their work and were appropriately trained in child protection training.

Standard 5.2

There was a management structure in place in the centre with clearly defined lines of authority and accountability. The centre manager was charged with overall executive responsibility for the day to day running of the centre. The inspectors found from the review of questionnaires and interviews that the centre manager was experienced and competent and staff were clear on their roles and responsibilities and of those held by senior management. The centre manager demonstrated leadership through supervision, team meetings, oversight of centre records, internal management meetings, attendance at senior management meetings, completing governance reports and presence in the centre. It was evident through these forums that a culture of learning, quality and safety was promoted within the centre. They were supervised by the director of services monthly. The internal management structure was appropriate to the size and statement of purpose and function of the centre. The centre manager was supported by a deputy manager who had defined roles and specific management responsibilities. They acted up in the manager's absence.

In line with centre policy there were systems in place for the identification, assessment and management of risk. It was found that risk assessments were reviewed in line with policy at team meetings. Centre management and staff in interview had a good understanding of the risk management framework. The deputy

manager was a member of the organisations risk assessment panel. The purpose of this panel was to improve the quality of the risk assessment process. At the time of the onsite inspection a risk matrix was being developed by the panel.

A service level agreement was in place between the centre and their funding body. The registered provider held responsibility for this process.

Standard 5.3

The statement of purpose detailed the admissions criteria, aims, objectives and ethos of the centre. The organisation's management structure and staffing arrangements were included in addition to the range of services provided by the centre to meet the young people's needs and the centre's model of care. Care practices, arrangements for ensuring the well-being and safety of young people were also outlined. The day-to-day operations of the centre was reflected with the next review date inserted, January 2021. The statement is included in the young person's information booklet and was publicly available in the centre.

In interview staff clearly described the model of care and demonstrated a good awareness of how it guided their work daily. The inspectors found from the overall inspection process that the child centred approach model of care was evident across all areas of care practices in the centre.

Standard 5.4

There were external and internal mechanisms in place that reviewed, monitored and audited the quality, safety and continuity of care provided to young people in the centre. The internal governance reports that captured the day-to-day operations of the centre were found to have been comprehensive and included issues brought to the attention of senior management. Oversight of senior management was evident with good clear direction and guidance being provided by them. Information relating to complaints, incidents and concerns were recorded, acted on, monitored and analysed. It was evident to the inspectors from the review of paperwork relating to placement planning, supervision, keyworking supervision and the various in house meetings that the centre was committed to ensuring that better outcomes for children were achieved.

As previously mentioned in the report the external auditing system required improvement to assess compliance with the National Standards for Children's Residential Centres, 2018 (HIQA).

At the time of this first inspection the centre had not completed an annual review of compliance with the centre's objectives. The inspectors recommend that senior management develop a tool to annually review compliance with the centres objectives and that timely action is taken to promote improvements in work practices to achieve better outcomes for children.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1** **Regulation 5**
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 provider must ensure that an audit tool that captures the centres approach for managing behaviour that challenges, based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed.	The procedure for reviewing and auditing approaches used for managing behaviour that challenges has been enhanced following a review panel meeting (14/04/20). The director of service developed an audit tool to examine approaches used for behaviours that challenges.	The director of service will ensure that regular auditing of the centres approach for managing behaviour that challenges takes place.
	The registered provider must ensure that SEN reviews are held in line with policy.	SEN review panel meetings are now pre-planned to take place every 6-8 weeks. The centre manager has assumed responsibility for scheduling these.	The director of services will ensure that SEN reviews take place as per schedule.