An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 018

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Kellsgrange Children's Services**
Registered Capacity:	**Four young people**
Date of Inspection:	**Announced**
Type of Inspection:	**09th ,12th & 13th October 2020**
Registration Status:	**Registered from 11th April 2018 to the 11th April 2021**
Inspection Team:	**Paschal McMahon** **Joanne Cogley**
Date Report Issued:	**21st December 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 in 2015. 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 11th April 2018 to the 11th April 2021.

The centre was registered to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was described as a relationship based model which is trauma informed. The model is underpinned by a theoretical approach across five core themes: food and mealtimes, the home environment, the language in use, boundaries and relationships. At the time of inspection there were four young people in residence.

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 looked 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 via teleconference 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 centre manager, senior management and the relevant social work departments on the 19th November 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 completed action plan (CAPA) on the 3rd December 2020. After further communication with the centre manager in respect of the CAPA, it was deemed to be satisfactory 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: 018 without attached conditions from the 11th April 2018 to the 11th April 2021 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operational policies
Regulation 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 registered provider had ensured that there were policies and procedures in place to operate the centre in compliance with the requirements of relevant legislation, regulations and standards. Since the previous inspection in December 2019 there was evidence of on-going work by the organisation's management team in relation to the development, review and updating of centre policies to ensure compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors also found evidence that the centre management had an increased focus on ensuring staff were aware of the policies and procedures through the re -induction of staff, on-going assessments as well as in team meetings and staff supervision.

Staff in interview demonstrated an understanding of centre policies and procedures and outlined policies which had been recently developed and reviewed. Not all staff demonstrated a clear knowledge of the National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors recommend that current on-going policy assessment process conducted by the centre management should also include a review of staff knowledge of the relevant standards and legislation as well as policies and procedures.

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.

The centre had a management structure in place that consisted of a centre manager, deputy manager and two child care leaders. The centre manager reported to the managing director who was the registered provider of the service. At the time of the last inspection, inspectors found that there was lack of clarity in regards to the roles

of the registered provider and the centre manager in the operation of the centre. A review of governance had since taken place and there was evidence from interviews and centre records that there were now clearly defined roles and responsibilities for all members of management that set out the lines of authority and accountability. There was evidence of good leadership within the centre. Staff in interviews and questionnaires expressed confidence in the centre manager and the deputy manager. Allocated social workers stated that they were satisfied that the centre was well managed and happy with the quality of care.

The centre had a service level agreement in place and the registered provider provided the funding body Tusla with a bi annual report.

The centre manager had overall responsibility and accountability for the delivery of care and there was evidence of their oversight in centre records and monthly audits. At the time of inspection, the manager was moving on from their post to manage one of the organisation's other centres and there was evidence of a transition plan in place for a new manager to assume responsibility for the centre.

From interviews and a review of records it was evident that the registered provider and the management team were reviewing the centre policies and procedures on an on-going basis to take account of the national standards and guidelines. Since the previous inspection there was evidence of learning and efforts made to improve the quality of care. This was evident in the introduction of a number of new auditing systems along with external audits which assessed the level of care and identified any deficits in quality and safety.

Inspectors found that a risk management policy had been developed since the last inspection along with a risk management framework for the identification, assessment and management of risk including the use of a risk matrix. Copies of individual risk assessments and safety plans were provided to inspectors. These risk assessments were carried out by the centre management and staff and were found to be appropriate and control measures were in place to mitigate these risks. Inspectors were informed that risks were discussed at staff handovers, team meetings and there was evidence of risks being reviewed at monthly management meetings.

The centre had a centre risk register and a corporate risk register which was maintained by the registered provider. A third risk register was in place for the management of the Covid 19 virus. The centre risk register reviewed by inspectors recorded environmental risks, but did not contain the most recent risk assessments for the young people. In addition, the corporate risk register viewed recorded risks in

relation to young people which were not corporate risks. In interview not all management and staff demonstrated a clear understanding of the risk management framework and would benefit from further training in this area. An external audit of the centre also identified the requirement for staff to develop a more risk aware approach to managing significant events including analysing events to identify if there is a need for further risk assessment or safety management planning. Inspectors recommend that the registered provider provides further risk management training for management and staff. The registered provider must also review and amend the centre risk and corporate risk registers to ensure that risks are recorded appropriately in the relevant registers.

There was good evidence from interviews and a review of centre records that the organisation had clear plans in place for the management of the Covid 19 virus. The centre had a trained Covid Compliance Officer and there were appropriate risk assessments on file. Risk assessments had also been updated in accordance with guidance from National Public Health Emergency Team (NPHET) and the government. Inspectors were informed that the centre had adequate supplies of anti-bacterial products, hygiene equipment, and personal protective equipment and a cleaning schedule was implemented. Plans were in place to manage visitors coming to the centre and the transportation of young people was risk assessed.

There was an internal management structure appropriate to the size and purpose of the centre. There were arrangements in place to provide adequate managerial cover when the manager took periods of leave. The centre had a delegation policy in place and inspectors were provided with a written record of managerial duties being delegated to members of staff detailing their responsibilities and designated tasks. The organisation had an on call system in place to support staff at all times in to manage incidents and risks in the centre.

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

The centre had a statement of purpose and function which described the aims and objectives of the service. The centre provided short to medium term residential care for four young people (male and/or female) aged 13-17 years on admission. The statement incorporated information on the admission process, how the centre planned to meet the needs of the young people and safeguarding measures in place. The statement had been updated since the previous inspection to include the management and staff employed in the centre. Information on the statement of

purpose was available to those who required it including young people, social workers and family members.

The inspectors were informed that the centre operated a relationship model of care. This model was being developed and implemented by a child care leader in the centre in consultation with an external social care consultant. At the time of inspection, the centre was in the process of implementing the model, there was on-going training being provided to staff and a time frame for implementation. The model of care was an agenda item in staff supervision and staff in interview referenced the model in their work with the young people. While the inspectors accept that the child care leader had extensive knowledge of the model of care, it is also required that the centre manager has an oversight and a guidance role in ensuring the model is implemented in practice. The registered provider must ensure that the centre manager is involved in the implementation and the roll out of the centre's new model of care framework, supporting the child care leader in the development of same.

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 had implemented a number of new audit systems since the last inspection to assess and monitor the quality of care, to improve practices and achieve better outcomes for young people. There was evidence the centre managers monitored the quality of care in the centre through oversight of all records, observation of staff practice and contact with the young people. The centre manager completed weekly and monthly audits which were sent to the registered provider for review. There was also a child protection audit carried out bimonthly that provided oversight and governance of child protection and safeguarding in the centre. The inspectors were satisfied that the template used for the weekly reports was of a good standard. However, inspectors noted that the registered provider's feedback on the reports reviewed was focussed primarily on the completion of administrative tasks with limited commentary on childcare issues and risk analysis. The reports also did contain action plans. Inspectors recommend that the weekly reports should include clear action plans specifying; identified actions, the person responsible, and timeframe for completion of tasks. The registered provider must also ensure that their feedback on the weekly reports includes a more detailed review and analysis of practice including risk management to inform improvements and better outcomes for young people.

The manager's monthly audits that were on file were benchmarked against the themes in the national standards. These were comprehensive audits assessing the centre's level of compliance with all eight themes of the national standards every month and involved a substantial time commitment from the manager in completing these audits. Action plans were developed following these audits showing evidence of follow up. Given the time commitment involved in completing these audits, inspectors recommend that the centre should consider reviewing fewer themes each month and focus on a more in depth qualitative analysis of these themes. The inspectors noted that the monthly audit template did not include any analysis of complaints or risk under the "Leadership, Governance and Management" (Theme 5) section and recommend that the report template is amended to include this information. External auditors also made a recommendation in an audit issued prior to inspection that a more concise monthly audit document should be developed to provide a more targeted approach to the manager's auditing of the operational systems allowing for an overall analysis and monitoring of outcomes for young people.

The inspectors found that while the registered provider had oversight of the monthly audits there was no formal mechanism or checks in place for the validation of the information contained in the audits. The registered provider must ensure that there are mechanisms in place to validate the audits either through carrying out their own independent audit or implementing a formal quality assurance system through the review of centre records, interviews with staff and young people etc.

The inspectors were satisfied from a review of complaint records on file and staff interviews that that the centre had worked on implementing their complaints process since the last inspection but further improvement was required. The inspectors found that there had been an increase overall in the recording of complaints and evidence that complaints had been an agenda item on weekly reports and at staff and management meetings There was also evidence that young people had used the Tusla " Tell us" complaints procedure. Staff in interview were unclear as to whether the complaints policy had been reviewed. The registered provider confirmed that while a new complaints system had been implemented the policy was in the process of being reviewed.

The centre maintained a complaint register which recorded details of complaints but this did not include a brief description of complaints or the complaint outcomes and the register should be amended to record this information. It was also unclear to inspectors from a review of complaint records at the time of inspection if necessary

follow up action had taken place following a number of complaints made by young people. Inspectors were satisfied from information received post inspection and interviews with the relevant social workers that appropriate action had been taken in these cases.

The centre maintained a monthly complaint audit record and there was evidence that complaints were an agenda item at both management and team meetings. An audit tool had been developed to analyse and monitor complaints. However, at the time of inspection there was only one audit form completed dated January 2020 on file for review and no evidence that audits had been completed since then. The registered provider must ensure that complaints are analysed and any trends identified are communicated to staff in the centre to promote improvements.

The registered provider was aware of the requirement for to conduct an annual review of compliance of the centre's objectives. The registered provider informed inspectors that they were implementing a monthly quality improvement plan which will inform the yearly report on compliance.

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

Actions required

- The registered provider ensures that current on-going policy assessment process conducted by the centre management includes a review of staff knowledge of the relevant standards and legislation as well as policies and procedures.
- The registered provider must provide risk management training for management and staff.

- The registered provider must review and amend the centre risk and corporate risk registers to ensure that risks are recorded appropriately in the relevant registers.
- The registered provider must ensure that the centre manager is involved in the implementation and the roll out of the centre's new model of care framework, supporting the child care leader in the development of same.
- The registered provider must ensure that the weekly audit reports include action plans specifying; identified actions, the person responsible, and timeframe for completion of tasks.
- The registered provider must ensure that their feedback on the weekly audit reports includes a more detailed review and analysis of practice including risk management to inform improvements and better outcomes for young people.
- The registered provider must ensure that there are mechanisms in place to validate the monthly audits either through carrying out their own independent audit or implementing a formal quality assurance system through the review of centre records, interviews with staff and young people etc.
- The registered provider must ensure that complaints are analysed and any trends identified are communicated to staff in the centre to promote improvements.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider ensures that current on-going policy assessment process conducted by the centre management includes a review of staff knowledge of the relevant standards and legislation as well as policies and procedures. The registered provider must provide risk management training for management and staff.	Centre manager brings two policies to team meetings. This will also now include discussion on relevant policies and framework which guides practice. Assessments will then be added to staff's Induction & Development files. These assessments will determine if further training is required. The organisations three centre managers along with the managing director within the company will meet and plan the training needed for staff. This training will be provided by management in-house. Practical assessments will also be carried out along with monitoring of development. Scheduled date for this training at this centre is December 17th 2020.	Managing director to include section on monthly auditing tool to ensure oversight of discussions, assessments, and outcomes. Also included will be an action plan to meet the needs of individual staff should it be required. Training Needs Assessments will also take place within the centre for all staff. Refresher training to link in with any/all updated policies and procedures (in-house and nationally). This training will also be Included as part of Induction Process.

	The registered provider must review and amend the centre risk and corporate risk registers to ensure that risks are recorded appropriately in the relevant registers.	The manager and managing director have separated the centre and corporate risk registers. This will also be covered in risk management training scheduled for the 17th December 2020. All Registers will be audited, and only relevant risks will be added to the appropriate folders.	Regular (monthly) auditing of the risk registers in management and team meetings.
	The registered provider must ensure that the centre manager is involved in the implementation and the roll out of the centre's new model of care framework, supporting the child care leader in the development of same.	Strategic meeting planned for December 2020 between model of care co-ordinator, managing director, centre manager and external model of care consultant and in-house psychotherapist. Once auditing tools are implemented for the model of care; the centre manager, model of care coordinator and managing director will then work on ensuring the practices flow through our policies and procedures.	Monthly strategic meetings and discussions between model of care coordinator, centre manager, managing director, external model of care consultant and in-house Psychotherapist. Child care leader will be moving to a fulltime role as model of care coordinator to ensure the auditing and implementation of the model of care, and centre manager will be a key participant in the implementation of the model of care at the centre.
	The registered provider must ensure that the weekly audit reports include action plans specifying; identified actions, the person responsible, and timeframe for completion of tasks.	The weekly audit now has a section entitled "Action Planning, Delegation & Timeframe". The managing director provides feedback to the centre manager under this section and tasks are completed	External auditor/ managing director to oversee audits/checks/follow-on's.

		by the manager or a delegated other person.	
	The registered provider must ensure that their feedback on the weekly audit reports includes a more detailed review and analysis of practice including risk management to inform improvements and better outcomes for young people.	Registered provider has added a new section to the weekly audit. This section includes the following heading: Risk management; this heading also has four subheadings for on-going risks; Impact on young person/s, monitoring of risk, expected or desired outcomes and outcome. The centre manager has undertaken a new monthly quality improvement plan. Two areas within the centre that a recognised for improvement will be addressed monthly. Areas addressed so far have included risk management training & staff report writing.	As part of recommended oversight, the managing director will visit the centre and review all actions set out in documents including the weekly audits. The manager also provides weekly feedback once the action plan has been completed.
	The registered provider must ensure that there are mechanisms in place to validate the monthly audits either through carrying out their own independent audit or implementing a formal quality assurance system	Managing director visits the house. Both announced/unannounced and completes monthly audits of different areas of practice.	Reviewed weekly as part of managing director's action plan. Managing director will also review when on site. Managing director to develop tool for monitoring and auditing risk.

	through the review of centre records, interviews with staff and young people etc. The registered provider must ensure that complaints are analysed and any trends identified are communicated to staff in the centre to promote improvements	Sections added to manager/managing director/ management and team Meetings Agendas to ensure discussion on all complaints, and feedback is provided to the staff team. In addition to this through the model of care implementation practices will begin by holding incident analysis whereby review and critique of incidents will be discussed and provide areas of learning in our responses.	Feedback will be provided to the team consistently, through; handovers, team meetings, management meetings and if necessary in supervision. The centre manager will also highlight trends upon review on the floor should it be required. Management have tools such as Quality Improvement Plans & Professional Development Plans. These supports will be made available to staff should management feel that they are needed. An open and transparent dialogue will also be kept with the social work departments and families if appropriate, to ensure that if trends are identified that impact on any young person, they are managed appropriately.