An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number :042

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Misty Croft**
Registered Capacity:	**Six young people**
Date of Inspection:	**30th November and 1st December 2020**
Type of Inspection:	**Announced**
Registration Status:	**Registered from the 17th of July 2018 to 17th July 2021**
Inspection Team:	**Linda Mc Guinness** **Joanne Cogley**
Date Report Issued:	**23rd December 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 monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in July2009. At the time of this inspection the centre were in their fourth registration and were in year two of the cycle. The centre was registered without conditions from the 17th of July 2018 to the 17th of July 2021.

The centre's statement of purpose set out that young people aged from twelve to seventeen years on admission are considered suitable to be placed on an emergency, short term, medium term or respite basis. Referrals were accepted from Tulsa's social work team for separated children seeking asylum and the out of hours social work department. The model of care was underpinned by a Maslow's hierarchy of needs and the purpose was to meet the primary, individualised needs of young people through a young-person-centred approach with the aim of successful integration. It was described as needs led, child centred care with a focus on care, health, integration, education and independence.

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 registered provider, senior management, centre manager and to the relevant social work departments on the 17th of November 2020. The findings of this report 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 042: without attached conditions from the 17th of July 2018 to the 17th of July 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 measures and systems were in place to ensure the centre was operating in compliance with the requirements of relevant legislation, regulations and national standards including Children First National Guidance for the Protection and Welfare of Children 2017. The organisation had policies and procedures in place which were valid from January 2020 to January 2022 unless specific updates were required. Inspectors noted that while the young person's booklet referred to the Tusla 'Tell Us' complaints policy it was not included in the centre's overarching policy and procedures document. Inspectors recommend that Tusla's 'Tell Us complaints policy is incorporated into the centre's own policies and procedures document.

The organisation had access to an information technology system where polices procedures and HR information was held. Staff received an electronic notification if policies had been updated or new information was disseminated. They had to confirm that these had been accessed, read and understood. There was evidence of discussions at team and management meetings and across supervision records relating to updated centre policies and procedures and staff informed inspectors they were consulted about policy review.

During inspection interviews, inspectors found that the team demonstrated an understanding of centre policies, procedures and relevant legislation and how these informed practice in the centre. While staff members were absolutely confident that they would report poor practice and felt safe to do so, they did not reference the whistleblowing policy in interview, and this should be refreshed at team meeting level. There were systems in place to assess gaps in compliance through various internal and external auditing systems and measures were implemented without delay if any issues were identified.

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.

There was evidence of robust management and leadership within the centre. A qualified and experienced person had been in the organisation for 14 years and held the post of social care manager for the past four years. The centre manager reported to the director of service who in turn reported to the managing director. The registered provider of the service held no operational responsibilities, these had been delegated to the managing director. Inspectors found that there were clearly defined roles and responsibilities for all members of management that set out the lines of authority and accountability. During inspection interviews and through returned questionnaires, staff members stated that there was strong and effective leadership. They felt supported by and expressed confidence in the centre manager and social care leader in the centre. Each staff member interviewed during inspection stated that external managers were accessible to them. All supervising social workers provided feedback to inspectors and they were satisfied that the centre was well managed. They expressed confidence in the manager and their commitment to support the team to meet the needs of young people and provide safe excellent quality care. Oversight of the leadership in the centre was provided by the director of service and managing director through professional supervision, management meetings and regular contact with the centre manager. The auditing system consisted of thorough quality assurance of comprehensive reports provided by the social care manager and the deputy manager.

There was a policy on corporate and clinical governance which placed an emphasis on being a learning organisation which strived to improve the service. This was also built into the mission statement and ethos whereby there was a commitment to learning from young people, social work departments, families and inspection and monitoring services. Inspectors reviewed a range of records including significant event reviews, supervision records, team and management meetings and found that this culture of learning was very evident in practice.

All levels of management and staff had job descriptions appropriate to their positions and each displayed a good understanding of their specific roles and responsibilities. The centre manager was the person in charge with overall executive accountability for the delivery of service and there was evidence of their oversight in centre records and in monthly reports to senior management.

There was a service level agreement in place with the Child and Family Agency and meetings took place quarterly to review the service and keep lines of communication open. The management team had been informed that the service level agreement had recently been rolled over for a period of 24 months. As stated previously, all operational policies and procedures were subject to regular review taking account of updates to regulations and national standards.

There was a policy relating to risk assessment which referenced relevant legislation and was connected to the health and safety statement. A new risk management system had been implemented in early 2020 and internal guidance had been provided in its use. There was evidence that the framework was understood by the staff team and they described how it worked in practice. Senior management had plans in place to implement a comprehensive formal risk management training programme for managers in the organisation. This would then be filtered down to each staff team through internal training.

The risk management framework relied upon the use of a risk matrix and review of the risk register evidenced that appropriate control measures were in place to mitigate against identified risks. The risk register was up to date and regularly reviewed. There was a process in place for escalating risk above a certain level to senior management and evidence from records showed that issues of concern were brought to the attention of the placing social workers in a timely manner. There was evidence that measures-were put in place to manage risks associated with the mix of young people and the possible negative impact if there were issues relating to cultural or political conflict, for example. Covid 19 featured heavily on risk management documents in the centre. Inspectors found that risk was discussed at staff handovers, team meetings and was regularly reviewed at management meetings.

Inspectors assessed the organisation's response to the management of risks posed by the Covid 19 pandemic. Inspectors reviewed the policies, procedures and contingency plans in place. These were frequently updated in accordance with guidance from National Public Health Emergency Team (NPHET) and government guidance. A robust cleaning schedule and procedures to manage visitors to the house were in place. There were adequate supplies of cleaning equipment, anti-bacterial products, and personal protective equipment on site. Team and management meetings were taking place remotely to ensure safety. While these were effective and facilitated the safe running of the centre, inspectors found that management meetings and records lacked the same structure as they did prior to the pandemic. The managing director must review the management meeting system and ensure that there are no gaps due to the remote nature of meetings during the Covid 19 crisis.

They must ensure that all previously set standing agenda items are still addressed and recorded appropriately. The proprietor had plans in place to facilitate self-isolation with support for young people upon admission as very often little information was known about those referred to the centre. There were contingency plans in place to manage staffing during the Covid-19 crisis. Recent recruitment ensured that there was an adequate panel of relief workers to provide cover in the event of a shortfall of staff due to an outbreak of the Covid-19 virus or a requirement to self-isolate.

There were appropriate arrangements in place to provide managerial cover if the manager was absent from the centre. There was a system in place to record managerial duties delegated to other appropriately qualified members of staff. Most of the staff team had specific 'officer' duties such as health and safety, fire safety, Covid-19 compliance or key-working oversight. There was an on- call system in place to support staff and to manage incidents and risks in the centre. There was a record maintained of calls made and the direction and guidance provided.

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 detailed statement of purpose that outlined the aims, objectives and ethos of the service, the management and staff employed in the centre, and the range of services provided to support and meet the care needs of the young people. The model of care was also detailed in the statement and staff interviewed during inspection demonstrated knowledge of the model and how it informed their everyday care practices with the young people. The implementation of the model of care was evident across centre records.

Social workers interviewed by inspectors were satisfied that the statement of purpose was reflected in the day-to-day operation of the centre. The statement of purpose was last reviewed on 20th January 2020 and was reviewed annually. Information on the statement of purpose was available to those who required it including young people and their social workers.

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.

Inspectors found that the quality, safety and continuity of care provided to young people within the centre was regularly reviewed to inform improvements in practices and realise the aims of the statement of purpose. There were effective auditing systems in place to assess the safety and quality of care and ensure practices were compliant with national standards and regulatory requirements. The director of services completed a director standard reporting form to highlight any issues requiring attention. An example of this was when a risk identified as high rated (12) was not brought to senior management in line with policy or when they disagreed with a risk rating for a particular issue.

There was evidence the centre manager monitored the quality of care in the centre through oversight of all records, observation of staff practice, through staff supervision and daily contact with the young people. The director of service and managing director also had a regular presence in the centre although this had been reduced due to Covid 19 safety planning. The centre manager reported directly to the director of service and there was evidence of regular management meetings. Inspectors found that auditing systems were sufficient to ensure continued compliance and a focus on service development. Exit interviews completed by young people were analysed for trends and patterns and were discussed with staff in team meetings. Inspectors found that this was a meaningful exercise and the physical structure of the house had been changed to incorporate ideas from young people about how their experience in the centre could be improved.

There was a complaints policy and procedure in place which was fully understood and implemented in practice. Complaints were notified as significant events and were tracked monitored and analysed for learning purposes at management level. There was an appropriate feedback loop to ensure any learning or required changes were communicated back to the staff team. Social workers told inspectors they were informed of complaints and were satisfied with the centre's response to any complaints made by young people.

The centre management were aware of the requirement for the registered provider to conduct an annual review of compliance of the centre's objectives to promote improvements in work practices and to achieve better outcomes for young people. This was currently underway and each manager within the organisation was

completing an annual review at the time of inspection, the outcome of which would inform a service improvement plan.

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

Compliance with standards	
Practices met the required standard	**Standard 5.3** **Standard 5.2** **Standard 5.4** **Standard 5.1**
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
5	None Identified		