An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 043

Year: 2021

Inspection Report

Year:	**2020**
Name of Organisation:	**Smyly Trust**
Registered Capacity:	**Five young people**
Date of Inspection:	**10th, 11th and 16th March 2021**
Type of Inspection:	**Announced**
Registration Status:	**Registered from 31st December 2019 to 31st December 2022**
Inspection Team:	**Linda Mc Guinness** **Lorraine Egan**
Date Report Issued:	**31st March 2021**

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 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 2001. At the time of this inspection the centre were in their seventh registration and were in year two of the cycle. At the time of the inspection the centre was registered without attached conditions from the 31st December 2019 to 31st December 2022.

The centre's purpose and function was to accommodate up to five young people of both genders from age ten to seventeen years on a medium to long term basis. The centre was a mainstream unit offering care based on a therapeutic community model. Their model of care was described as being based on the principles of a therapeutic community which included attachment, containment, communication, citizenship, reflection, education, agency and community. There was a focus on hearing the voice of the young people and empowering them to be active in their lives. There were four young people resident in the centre at the time of this 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 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 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 was a blended inspection of remote and onsite activity. It was carried out through a review of documentation, a number of online interviews and a visit to the centre to review the premises and meet young people.

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 19th March 2021. 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 26th March 2021. This was deemed to be satisfactory and the inspection service received an updated suite of policies and procedures and a commitment to implement all actions set out in the CAPA.

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: 007 without attached conditions from the 31st December 2019 to 31st December 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16 – Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

Inspectors found that there was evidence of good practice in relation to safeguarding and child protection and that the centre was operating in compliance with Children First: National Guidance for the Protection and Welfare of Children, 2017. Organisational management had reviewed the suite of policies and procedures throughout 2020. The organisation's child protection and safeguarding policies were being reviewed again at the time of this inspection using the Tusla 'Child Safeguarding a Guide for Policy Procedure and Practice' as a template. Training was to be provided to the staff team upon completion. During inspection interview some staff members were unfamiliar with the centre's code of conduct and this should be reviewed in team meetings as a matter of priority. The centre manager recently implemented a system to record and to monitor any child protection concerns which did not meet the threshold for reporting to Tusla. This was communicated to all staff by email.

A child safeguarding statement dated January 2021 was in place and displayed appropriately, with written confirmation from the Tusla Child Safeguarding Statement Compliance Unit that it met the required standard. There was a version of this statement in place for young people contained within a personal safety information pack. This pack also included information about advocacy groups, the rights of young people, the complaints procedure and access to information.

Staff training records evidenced that each staff member had been provided with training in child protection and also completed the Tusla E-Learning module: Introduction to Children First, 2017. The organisation had also facilitated child protection training from an external company across two days in January 2021. Through interviews and review of questionnaires inspectors found that the staff team were familiar with child protection reporting procedures and their statutory obligations as mandated persons under the Children First Act, 2015. Where child protection concerns arose they were reported without delay via the Tusla online Portal. There was prompt action with strategy meetings taking place and the centre

staff worked closely with specialist services regarding risk assessment and safety management where appropriate. Inspectors saw evidence in centre records that child protection was a standing agenda item in staff team meetings, management meetings and was included in manager's audits.

There was a policy on bullying and harassment and there was evidence that the team were alert to issues of bullying in the centre and that early action was taken through community meetings. Young people confirmed to inspectors that staff took the issue seriously if it arose and did not let it get bigger. Inspectors recommend that the bullying policy is reviewed to so that it links more effectively to child safeguarding and that it includes reporting in cases where bullying amongst peers is considered abusive. It should also have specific reference to situations or circumstances where young people are more vulnerable to bullying.

The centre had a policy in place in respect of electronic communication and safeguarding young people online. Online safety was addressed through keyworking and individual work with young people. Inspectors found that the centre had conducted risk assessments and put measures in place to limit access to mobile phones if child protection concerns arose. Young people who spoke to inspectors confirmed that it was fully discussed and explained to them if such measures were implemented.

Young people's social workers were sent copies of risk assessments and safety plans. There was evidence across centre records that the management and team had worked collaboratively with young people's placing social workers to promote their safety and wellbeing. Strategy meetings took place and clinical guidance was provided to the team from the organisation's consultant in respect of implementation of the model of care.

The centre conducted pre-admission risk assessments for young people prior to admission to identify and address areas of vulnerability and risk. The young people's risk assessments and safety plans were reviewed by the inspectors who found that there was evidence that these adequately addressed identified areas of vulnerability. Collective risk assessments also took place to ensure that any possible negative impact of young people on each other was responded to robustly.

There were agreed procedures in place to inform parents of allegations of abuse.

The centre had protected disclosures policy to facilitate staff to raise concerns or disclose information relating to poor practice. Inspectors found through interviews that staff members were familiar with the policy and that they would confidently report poor practice without fear of adverse consequences.

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

There was a behaviour management policy and a positive approach to managing behaviour policy which was aligned to the model of care. There was a specific focus on avoiding sanctions where possible and young people were involved in restorative discussions about natural consequences for property damage or risk taking behaviour. The policy did not rely on monetary rewards to elicit change. It was focused on areas such as praise and recognition, developing connections and educational support amongst others. There was evidence that policies and practices in the centre were cognisant of the United Nations Convention on the Rights of the Child.

Physical restraint was not a feature in this centre. All staff had received training in the recognised model of behaviour management in use however some refresher training had been delayed due to the Covid 19 pandemic. Refresher courses had only brought staff up to a certain level of the programme and some staff members were not certified to use physical interventions at the time of this inspection. The individual crisis management plans (ICMPs) in place to assist and support staff and the young people to manage difficult behaviour had not been amended accordingly. The centre manager must ensure that each young person's ICMP clearly states if there is a contraindication to the use of restraint or what types of physical interventions were permitted if required.

Interviews with staff and review of records showed that they were acutely attuned to individual needs of young people and were aware of the underlying causes of challenging behaviour. They were able to describe the impact of trauma, neglect or abuse and how these could impact the behaviours of young people. There was evidence of regular review of risk assessments, behaviour management and safety plans. Social workers interviewed during the inspection stated that the team were consistent and stable, that they used positive relationships to support and to challenge young people. This was evident through review of keyworking records and individual work across young people's files. Training had been provided in relation to the model of care during induction and inspectors found that there was on-going

guidance and direction from a consultant psychotherapist to support the team in implementing the principles of the therapeutic community. A second consultant facilitated a process group which helped staff to manage the impact of the work and respond effectively to young people's behaviours. All necessary information was provided to facilitate effective management of behaviour. External clinical specialists also provided advice and guidance to the team where required.

Inspectors met with three of the young people resident in the centre. They were all very happy with the care being provided, they said they had made significant progress during their time there and stated they liked the manager and staff team. They stated that they were listened to and that the staff supported them with issues or difficulties they may have both in community meetings and through work with their keyworkers.

There was a system in place to audit compliance with national standards and a recent analysis of significant events and behaviour management took place where trends and patterns were highlighted for organisational learning.

Each young person had an up to date individual absence management plan which was required under the *Children Missing from Care: A Joint protocol between An Garda Síochána and the Health Services Executive, Children and Family Services, 2012'*.

There was a policy in respect of the use of restrictive practices which inspectors found would benefit from further review in terms of content and practice. There had been no use of physical interventions in the 12 months prior to this inspection. Some restrictive measures such as limitations on mobile phones were appropriately recorded however others such as the use of a monitor, restricted access to sharp knives, or room searches were not recorded as restricted practices. There was a lack of evidence at team and management meetings that restrictive practices were reviewed routinely to establish if they needed to remain in place. The director must review the policy and procedure and ensure that the staff team are familiar with what constitutes a restrictive practice. They must ensure that these are all recorded appropriately and monitored on a regular basis.

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Inspectors found that an open culture was promoted in the centre and staff members who were interviewed were confident that they would challenge each other's practice

if required. The director of services had a regular presence in the centre which was reduced at times based on Covid-19 risk assessments. Young people and staff confirmed that they were familiar with the director and that they were approachable and responsive.

There were mechanisms in place to receive feedback from social workers, parents on the care being provided. There was also a survey completed with young people in 2020 to assess how the centre was complying with national standards and meeting their needs. This had been analysed and bar charts and spread sheets were available for review. This was a really useful piece of information and there was evidence that this was discussed at senior management level and it was included in the annual report and service development plan. There was evidence that the staff and management team were in regular contact and worked closely with social workers, advocates for young people and family members where appropriate.

The inspectors found that the centre had a written policy and procedure for the recording and notification of significant events. Supervising social workers confirmed that these were professionally written, received in a timely manner and that there was excellent communication with the team and management. There was evidence that the social care manager and director had oversight of all significant events and incidents that occurred in the centre. Review of the significant event register found that there were low levels of incidents. There was good evidence of strategy meetings and communication with all relevant people if issues arose. Significant event review meetings (SERG) took place in line with organisational policy and while there was evidence of review and reflection, the minutes of these meetings would benefit from more detail relating to deconstructing and analysing interventions and outcomes for learning purposes. Social workers and staff members confirmed that learning was communicated back to them following SERG and that young people's plans were updated promptly if required. There was also evidence that debriefing was provided to staff following incidents in the centre.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**3.3**
Practices met the required standard in some respects only	**Standard, 3.13.2**
Practices did not meet the required standard	**None Identified**

Actions Required

- The director must ensure that all staff are familiar with the centre's code of conduct.
- The director must review the restrictive practice policy and procedure and ensure that the staff team are familiar with what constitutes a restrictive practice. They must ensure that these are all recorded appropriately and monitored on a regular basis.
- The centre manager must ensure that each young person's ICMP clearly records what physical interventions are permitted and if there are any contra-indications to physical restraint.

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 organisation had a working group which focused on policy development and also considered learning from inspection processes. All issues requiring action relating to fire safety during the last inspection of this service had been implemented in full. They had updated their suite of policies in 2020 to bring them in line with the National Standards for Children's Residential Centres, 2018 (HIQA), and all relevant legislation and national guidance. Policies were updated by this group as required

taking account of revised legislation and updates to national policy. There was evidence of discussions at team and management meetings relating to new and updated centre policies and procedures.

Through interview and review of questionnaires, inspectors found that the manager and staff were aware of centre policies and procedures and relevant legislation including Children First and how these informed practice in the centre. As mentioned previously, the team would benefit from review of the code of conduct and the centre manager informed inspectors that training would be provided in the revised child protection policy once it was completed and signed off. There were systems in place to identify gaps in compliance through various internal and external auditing systems. The audit tools were aligned with the National Standards for Children's Residential Centres, 2018 (HIQA) and there was strong evidence of a commitment to fully implement these standards.

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.

Inspectors found evidence of good management and leadership within the centre. The centre manager had been in post for twenty three years. There was evidence of strong leadership and staff in interview and through questionnaires expressed confidence in the centre manager and deputy manager. Supervising social workers who provided feedback to inspectors were satisfied that the centre was well managed and they commended the manager and their commitment to supporting the team to meet the needs of young people. Oversight of the leadership in the centre was provided by the director through, audits, monthly management meetings, daily contact with the centre manager and onsite visits when Covid-19 risk assessments allowed. They also provided professional supervision to the centre manager in line with organisational policy.

Inspectors reviewed a range of records including significant event reviews, supervision records, team and management meetings and found that there was evidence of a culture of learning in the centre, although records would benefit from more detail. Inspectors also found that analysis of complaints and restrictive practices required more formal review and monitoring which also required an update to the relevant policies.

There were clearly defined governance arrangements and structures in place with clear lines of authority and accountability. 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 monthly reports. There were regular reports to and meetings with, the board of management. All levels of management and staff had job descriptions appropriate to their positions and they displayed a good understanding of their specific roles and responsibilities.

There was a service level agreement in place with the Child and Family Agency and meetings took place on a bi-annual basis. Team meeting minutes and staff supervision records evidenced discussions in relation to policies, procedures and national standards. Some of these meetings lacked detail to fully represent the governance and oversight in place.

There was a risk management system in place, training had been provided in the use of the matrix and the scoring system and there was evidence that the framework was understood by the staff team. Inspectors reviewed individual risk assessments for young people which were appropriately translated into behaviour management plans or safety plans. It was noted that one risk assessment did not use the scoring matrix and instead rated risks as high, medium or low. The centre manager explained that they were waiting on input from the social work department to complete the document however this had not been completed in a timely manner. The director must ensure that the risk management framework is utilised consistently in all young people's planning documents.

There was a clear process for escalating risk and inspectors found that that any issues of concern were brought to the attention of placing social workers in a timely manner. There was evidence that measures were put in place to manage risks associated with peer interactions with an appropriate focus on child protection.

Inspectors assessed the organisation's response to the management of risks posed by the Covid 19 pandemic. Inspectors reviewed the protocols, 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. Staff team and management meetings were taking remotely but they were not reduced in frequency and were well attended. There were contingency plans in place and 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 requirements of staff to self-isolate.

There was a system in place to record managerial duties delegated to the deputy manager. There was a qualified and experienced deputy manager to provide cover when the manager was absent from the centre. There was a system in place to support staff to manage incidents and risks in the centre outside of office hours. Formal on call arrangements were not included in job descriptions or contracts and these duties were not specifically remunerated. The director stated that they had been informed that this was being discussed at service level agreement level with Tusla.

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

Inspectors reviewed the detailed statement of purpose and function which was last updated in March 2020. It 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 therapeutic community model of care was described 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 language of the model of care was evident across a range of centre records.

Social workers interviewed by inspectors commented positively on the implementation of the model of care in the day-to-day operation of the centre. Information on the statement of purpose and model of care was available to those who required it including young people, social workers and family members.

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 in an effort to achieve better outcomes for young people. Two external consultants provided robust support to ensure that the centre was adhering to the principles of the therapeutic community to meet the identified needs of young people.

The centre was also audited annually by an organisation they were affiliated with in the UK to ensure continued compliance.

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. There were internal and external auditing systems in place to assess the safety and quality of care and ensure practices were compliant with national standards and regulatory requirements. These audits had been mapped to the National Standards for Children's Residential Centres, 2018 (HIQA) and the director had conducted a number of themed audits across 2020. These were detailed and focused on outcomes for young people however some improvements were required. While issues noted as requiring action were responded to in a timely manner, deficits in tracking of complaints and restrictive practices were not highlighted. Inspectors also found that actions emanating from these audits would benefit from being more specific.

The centre manager reported directly to the director of service and there was evidence of monthly management meetings across the organisation. The director also had a regular presence in the centre depending on Covid-19 risk assessments to keep footfall in the centre to a minimum during high level restrictions.

Inspectors found that the complaints policy and procedure in place required updating to ensure that complaints of all levels were recorded in a way that they could be tracked, monitored and analysed for learning purposes. While formal complaints were recorded and managed appropriately other lower level, non notifiable complaints were not recorded on a register or in a way that facilitated effective review. There was evidence from interview with young people and review of returned questionnaires that young people were aware of the complaints process. They utilised the community meetings in an effective way to resolve issues of dissatisfaction and these were discussed at team meetings. There was however, a lack of evidence that complaints were discussed and reviewed to identify any patterns or trends to inform service improvements.

There was an annual review of compliance and review of the centre's objectives which incorporated a service improvement plan to promote improvements in work practices to achieve better outcomes for young people.

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 5.1** **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 director must ensure that the risk management framework is utilised consistently in all young people's planning documents.
- The director of service must ensure that the complaints policy is updated and that all complaints are recorded, monitored and analysed for learning purposes and service development.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director must ensure that all staff are familiar with the centre's code of conduct.	The code of conduct was reviewed at the policy review group meeting on the 25th March 2021. It will be reviewed with staff at the team meeting on the on the 30th of March. Staff will be asked to read and sign one copy which will be held in the staff office for all staff to refer to in future. The code will be included in the policy and procedure document and employee handbook.	The code of conduct will be included as an integral part of induction to the centre. It will be reviewed annually as part of routine policy review and be included in regular review and discussions of policies at team meetings. Any changes to legislation which may affect the code of conduct will be added and communicated to all staff.
	The director must review the restrictive practice policy and procedure and ensure that the staff team are familiar with what constitutes a restrictive practice. They must ensure that these are all recorded	The director & policy review group reviewed the policy on the 25th March 2021. A list of restrictive practices will be drawn up from an organisational point of view. The manager will review the restrictive practices pertaining to each individual	The restrictive practices in operation will be added on to the weekly report to the director to ensure effective review and monitoring. If organisational changes are to occur, they will be communicated through team meetings. Individual restrictive practices will be reviewed within set timeframes by

	appropriately and monitored on a regular basis.	young person and a centre register will capture all restrictive practices in place. A review date will be added to each restrictive practice and supervising social workers will be consulted as part of this process. This will be completed by the 31st of March 2021. Restrictive practice is now part of the weekly report to the director who will track the use of restrictive practice.	manager, key worker in consultation with social workers. This will be communicated to all staff via handover/team meetings. Restrictive practice will be a set agenda item on the SEN Review Group & management meetings.
	The centre manager must ensure that each young person's ICMP clearly records what physical interventions are permitted and if there are any contra-indications to physical restraint.	The manager has addressed with each key worker the issues of restraint and where there are no contra-indications to physical restraint an exploration as to what physical interventions can be used and in what circumstances. This was communicated to all staff on Tuesday the 23rd of March at the child protection staff meeting. All ICMP's have been updated.	ICMP's are reviewed on an on-going basis and child protection staff meetings are also held during the year where all ICMP's are discussed at a team level. The issue of restraint/physical interventions will be discussed and reviewed at this forum. Contra-indications to restraint will be added to individual crisis management plans as required and communicated promptly to the staff team.

5	The director must ensure that the risk management framework is utilised consistently in all young people's planning documents.	The centre manager has reviewed the system has amended the one risk assessment which was outside the framework. This was sent to the supervising social work department on the 23rd of March 2021.	Implementation of the risk management framework/policy as part of the child protection system will be reviewed during monthly management meetings.
	The director of service must ensure that the complaints policy is updated and that all complaints are recorded, monitored and analysed for learning purposes and service development.	The complaints policy was reviewed on the 25th March. Actions to capture trends and patterns of complaints that are dealt with in community meetings and in local resolution meetings internally. They will be managed by the centre manager and held in the complaints main file. This was completed on the 25rd of March 2021	Complaints, internal / local and external /formal will be part of the SEN internal review meetings which are every six to eight weeks by senior management and staff. Any identified trends or patterns will inform service review and be incorporated into annual service improvement plan if required.