An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 114

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Terra Glen**
Registered Capacity:	**2 young people**
Type of Inspection:	**Announced themed inspection**
Date of Inspection:	**10th and 11th March 2020**
Registration Status:	**Registered without attached conditions from 14th March 2019 to 14th March 2022**
Inspection Team:	**Linda Mc Guinness** **Lorna Wogan**
Date Report Issued:	**19th May 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 on the 14th March 2016. At the time of this inspection the centre was in its second registration and was in year one of the cycle. The centre was registered without attached conditions from 14th March 2019 to 14th March 2022.

The centre was registered to provide accommodation two young people of both genders from age thirteen to seventeen years on admission. Their model of care was described as relationship based, informed by both pro social model and attachment theories. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.1, 2.2, 2.3, 2.4, 2.5, 2.6
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

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 departments on the 14th 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 28th 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: 114 without attached conditions from the from 14th March 2019 to 14th March 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5 Practices and Operational Policies
Regulation 8 Accommodation
Regulation 13 Fire Precautions
Regulation 14 Safety Precautions
Regulation 17 Records

Theme 2: Effective Care and Support

Standard 2.1 - Each child's identified needs inform their placement in the residential centre.

There were two young people living in the centre and there were no new admissions to the centre since 2017. The centre had a written policy on admissions in their policies, procedures and staff handbook which was dated 2018. The admissions policy for the centre took account of the purpose and function for the centre. It did not yet include the rights of young people or refer to national standards, requirements of regulations and legislation. The organisation had commenced a review of all policies to ensure they are fully aligned with the National Standards for Children's Residential Centres, 2018 (HIQA). This was due to be completed by September 2020.

There was a robust admission process in place which included consultation with social workers and others to ensure that the placement would be suitable to meet the needs of young people referred. This was implemented subsequent to the placement of the current resident group. The admission policy outlined that a written up to date care plan must be provided prior to admission or within one week of placement. This was to ensure that a comprehensive assessment of need was available to inform the placement in line with the purpose and function. The team completed a detailed and comprehensive developmental audit at the start of each young person's placement which was a complete overview of their presenting needs and included any attachment issues they may have. It gave good guidance as to how the model of care would be utilised to meet identified needs.

The admissions procedure in place included pre-admission risk assessments and impact risk assessments to ensure that the needs and rights of young people already resident were considered prior to a new placement. Written information was provided to young people and their parents. The transition process generally took

place over a two-week period, but there was room for flexibility if required in consultation with social work departments who were familiar with young people. This transition process was clearly outlined in the policy and young people who spoke with inspectors confirmed that they had an opportunity to visit the centre and become familiar with the staff and other young people prior to their admission.

Standard 2.2 - Each child receives care and support based on their individual needs in order to maximise their personal development.

Inspectors found that there were significant delays in receiving a care plan for one of the young people in the service. This was despite evidence that the centre manager and team had been requesting this for some time. A statutory child in care review meeting took place on 25/11/19 but a care plan was not received until the day of the onsite inspection in March 2020. There were no minutes for this statutory review with the exception of centre records which were used to update the placement plan. It was difficult to track how decisions made at the statutory review were implemented. The social care manager had requested an emergency review but the social work department felt it was not warranted at that time. The inspectors found that care planning did not take place within regulatory timeframes for this young person. The care plan on file did not state the overall aim of the placement, it was not signed, there was no review date and the actions to meet needs were not specific. It was also noted that there were errors on the plan. This is inadequate to inform effective placement planning and must be addressed.

There was an up to date care plan in place for the other young person and evidence that the centre worked in collaboration with the social worker to implement the agreed goals.

Each young person had an up to date placement plan on file which was prepared by the keyworker with input from the team and oversight of centre management. These plans identified supports required to ensure positive outcomes. They were reviewed on a monthly basis and specific goals and tasks were identified. Young people were afforded opportunities to review and add to these plans and families contributed through the care planning process and regular communication with the team. Inspectors found that actions in respect of young people's participation could be addressed more robustly within the centre. Both young people were in the aftercare planning phase of their placements. Inspectors found that they had been asking for more flexibility in relation to their free time but could not be facilitated due to the way the roster was scheduled. This was not age appropriate and inspectors

recommend that this is reviewed in consultation with supervising social work departments.

Young people were facilitated to access external supports in consultation with supervising social work departments. The team had brought in external professionals to support them with specific presenting issues of the young people. The organisation was currently recruiting an in-house psychologist to enhance supports to young people and the staff teams. The two young people had access to a variety of services. There was a delay for one young person's access to specialist support but there was evidence that the management and staff team had advocated on their behalf. There was urgency for a specialist reassessment for one young person and the social work department were aware that further delay could have significant impact on their aftercare planning. A date was scheduled but further postponed due to the current public health crisis. The social worker stated it would remain an absolute priority.

All those interviewed internally and externally as part of the inspection process highlighted issues regarding communication and inter-disciplinary/inter-agency cooperation in the planning and on-going care of one young person. Inspectors acknowledge the complexities of this case and were assured that it was being reviewed at the most senior level in the social work department under complex case protocols. Written correspondence to this social work department was mostly not responded to in writing however the supervising social worker provided evidence of frequent and regular telephone communication between them and the team. Communication and planning between the staff team and social work department for this young person must improve to ensure effective implementation of the goals of the care plan and placement plan.

Standard 2.3 - The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

Inspectors found that the centre was in good structural repair and the layout and design was suitable for providing safe and effective care. It was clean, decorated to a good standard and maintained appropriately. Inspectors found it to be warm, welcoming and adequately lit, heated and ventilated. There were sufficient bathroom facilities. Cleaning schedules were audited on a regular basis. Each young person had their own room which they could decorate to their own taste. Young people could also contribute to the decoration of the shared living spaces if they so wished. The centre was homely and there were photos displayed. There were adequate

facilities for indoor recreation and, given the age of young people, outdoor recreation was generally facilitated in the community. There was space for young people to meet family, friends or professionals in the centre privately if they so wished. There were also adequate and secure storage facilities for their personal belongings.

The centre provided evidence that they complied with the requirements of fire safety, building regulations and health and safety legislation. Fire drills took place regularly however, inspectors highlighted that annually a fire drill must be conducted during hours of darkness. There was a health and safety statement dated 2018 which had been read and signed by all staff. This must be reviewed, updated and communicated to all staff.

There were appropriate policies, procedures and reporting mechanisms in place for the management of possible risks to residents, staff and visitors. A review of the health and safety documentation found that internal and external audits took place regularly and that non-compliance reports were sent to centre management for immediate action. Appropriate resources were made available to facilitate actions if required. There were appointed health and safety and fire representatives on the staff team. Young people's care records included sections for recording any accidents or injuries and these were promptly reported to relevant persons.

The centre had two leased vehicles which were serviced and maintained regularly. These were driven by fully licenced personnel and evidence of tax, appropriate insurance and roadworthiness was provided during inspection.

Standard 2.4 - The information necessary to support the provision of child-centred, safe and effective care is available for each child in the residential centre.

There was a well maintained care file for each young person which facilitated ease of access and effective planning. As mentioned previously, there was significant delay in receiving a care plan and statutory review minutes for one young person. The files held all other information required by regulations (with the exception of immunisations which had been requested) and they were kept securely in locked cabinets in line with legislation, regulations and best practice . Inspectors found reports were written to a good standard and training had been provided to facilitate this. Files were audited regularly by the social care manager and through external quality assurance processes and any deficits were addressed promptly.

Standard 2.5 - Each child experiences integrated care which is coordinated effectively within and between services.

There was evidence on young people's care files that communication within the centre and to external professionals took place to facilitate effective planning and positive outcomes. Review of centre records and care files evidenced good inter agency and inter disciplinary communication.

Notwithstanding the difficulties already noted, the team worked closely with families and other professionals through the care planning and placement planning processes. This was to ensure that there was a timely preparation for leaving care and discharge plan in place for each young person as they approached 18 years of age. The team were familiar with the Tusla National Aftercare Policy for Alternative Care 2017. Both young people in the service had been allocated an aftercare worker and an aftercare needs assessment had taken place for one at the time of inspection. There was an aftercare co-ordinator appointed within each centre within the organisation Inspectors found a high standard of work from the staff team in relation to aftercare. The service had worked collaboratively with community housing bodies to identify and develop aftercare accommodation for young people leaving their services.

When young people move on from the centre they are provided with a memory box of their time there including photos, certificates and other things important to them. If young people were moving on to other services appropriate information would be passed on in consultation with supervising social work departments. There was evidence that young people were consulted about their wishes and plans and that on-going support would be provided during their transition from the centre. Families were also consulted and included in this process if deemed appropriate and in the young person's best interests.

There a system in place for gathering information relating to young people's experiences of their time in the centre. They are asked to complete an exit interview when they move on and the information is reviewed by the director of operations and the director of service. The outcomes from these reviews were then reflected in the annual audit and report. They were also reviewed by the Tusla National Private Placement Team every six months.

A system analysis review is also conducted by the service following an emergency discharge or discharge which was not in line a young person's care plan. These processes are used for service improvements and service development purposes.

Standard 2.6 - Each child is supported in the transition from childhood to adulthood.

Both young people in the centre were at different stages of preparing for aftercare. There was evidence that they were fully involved in the discussions and decision making in respect of their plans and the transition to adulthood. Families were also included in planning where appropriate. In the case of the oldest young person there was an aftercare plan in place which identified their needs, options and supports required. This young person informed inspectors that they felt supported by the team to plan for the future. They held their own copy of the aftercare plan. This young person was staffed on a 2:1 basis in the centre for a significant period of time. It seems that the rationale for this had changed over time and that while it may still be required at some level it should be reviewed in consultation with the young person, their social worker in the context of planning for aftercare and transition to independent living.

The placement plans for each young person had an appropriate focus on development of independent living skills. There was ample evidence of keyworking and individual work from the team offering advice guidance and assistance to young people to prepare them for this significant transition. These included healthy living, budgeting, paying bills, meal planning, accessing supports amongst others. The social care manager indicated that young people would be facilitated to access their files and obtain copies of important documents before they move on. Decisions to facilitate young people's access to their social work files were risk assessed carefully to ensure that young people were able to process the information without impacting negatively on their well-being.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 17** **Regulation 13** **Regulation 14**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 2.3** **Standard 2.4** **Standard 2.5** **Standard 2.6**
Practices met the required standard in some respects only	**Standard 2.1** **Standard 2.2**
Practices did not meet the required standard	**None identified**

Actions required

- The director of service must ensure that the centres admission policy document and the centres statement of purpose is updated to include the rights of young people, national standards and requirements of regulations and legislation
- Senior management must ensure that communication and planning issues between allocated social work department for one young person and the staff team are addressed collaboratively to ensure effective implementation of the goals of the care plan and placement plan.
- The centre manager must ensure that the Health and Safety statement is reviewed, updated and communicated to all staff.

Regulations 6 Person in Charge
Regulation 7 Staffing

Theme 6: Responsive Workforce

Standard 6.1 - The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found that there were sufficient numbers of staff with the required qualifications, experience and competencies to meet the needs of young people and provide child centred and effective care. The organisation regularly undertakes workforce planning and has a backup of relief staff to cover periods of annual leave or sick leave. This was to ensure that young people were cared for in as much as possible by people who know them and that they are familiar with. There was a staff recruitment drive taking place at the time of inspection and a rolling recruitment programme to ensure sufficient staffing. There were a number of measures in place

to promote staff retention and continuity of care for young people There was also a scheme in place to reward employees who excelled in their work. Staff exit interviews took place and these informed approaches to recruitment and retention of staff. Senior management reported that these measures had made a positive impact on staff stability across the service.

The staff roster took account of the skills and experience on the team. There was an on call system in place which adequately provided for support and cover during evenings and weekends. However, inspectors found that full records of on-call interactions and decisions made were not kept for review and oversight purposes. Centre management should ensure that this occurs.

Standard 6.2 - The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

In general, there were robust recruitment measures in place although on one occasion due to unforeseen circumstances only one person interviewed a prospective employee before their appointment to the team. This was not in line with best practice and safe recruitment and must not occur. Inspectors found that vetting was in line with the National Vetting Bureau (Children's and Vulnerable Person's Act 2012 – 2016) and the Department of Health circular in respect of recruitment and selection of staff to children's residential centres, 1994. Garda vetting was re-submitted after two years in line with best practice. Inspectors found that there was no risk assessment on file where an issue arose through the Garda vetting process for one staff member. This must be implemented in line with organisational policy.

All but one of the staff team held a recognised qualification in social care or held a relevant qualification. This person would have a recognised qualification by June 2020. The centre manager was appropriately qualified and had in excess of five years post qualification experience working with children. Each staff member had a signed contract of employment and job description although the date of appointment was not on one of the records reviewed during inspection. Inspectors noted that the personnel files were well organised and maintained and were audited for compliance with regulations through internal governance systems.

Review of the organisation's policies and procedures evidenced a written code of conduct and in general, staff members interviewed were familiar with its purpose and

content. It may be beneficial for the centre manager to revisit this at a team meeting in the near future.

Standard 6.3 - The registered provider ensures that the residential centre supports and supervises their workforce in delivering child-centred, safe and effective care and support.

There was evidence that the staff team were familiar with guiding policies and procedures and that they understood their roles and responsibilities. There was a reporting structure with clearly identified line management responsibility and accountability.

There was evidence that the staff team were able to exercise professional judgement and they were supported to use their initiative in their work with the young people. Team meetings and handover meetings were supportive forums where staff members were held accountable for their work. Staff members interviewed during inspection were confident that safe, child centred care was being provided and that each person was responsible for the delivery of a quality service. They indicated that it was a professional responsibility to identify poor practice if it existed and that they were confident that action would be taken. This was evident in practice across review of records.

There was a risk management framework in place and measures were put in place to mitigate any risks to staff if they were identified. This included measures such as 2:1 staffing in the centre vehicle for a period for example.

Review of records including team meetings, supervision, management meetings and handovers evidenced reflective practice and this was in line with the model of care in use. There was an organisational approach to professional development and learning. The staff team were supported to attend training programmes and conferences in support of skills development in their work. They were expected to bring this learning back to colleagues in the team meetings.

Effective communication within the centre was also evident from review of the above records. This was also communicated to inspectors through interviews and returned questionnaires. Team meetings took place regularly and were well attended. There was evidence of actions emanating from these meetings with appropriate follow up. Inspectors found that supervision was generally taking place within the timeframes set out in organisational policy (every four to six weeks). Supplementary supervision

was also provided if deemed necessary, for example to newer members of staff or during periods of stress or crisis. While supervisors had been trained in the delivery of supervision, training for supervisees was not yet in place and must be implemented to comply with requirements of the National Standards for Children's Residential Centres, 2018 (HIQA).

There was a system in place for annual review of each staff member's performance through a formal appraisal. There was a written record which was signed by both parties. Inspectors recommend that the appraisal process is explained again to the staff team as there was some confusion as to its purpose with some staff only relating it to their remuneration. Centre management must ensure that all aspects of the appraisal template are completed. Only one appraisal was outstanding at the time of inspection and was being scheduled.

There were robust polices in place in respect of support to the staff team. There was evidence that the management team understood and appreciated the sometimes stressful nature of the work. This was confirmed through interviews with the staff team and in returned questionnaires. There were internal supports in place such as scheduled and supplementary supervision, individual and team debriefings and reflective practice. Individual staff members were supported with time off and medical attention if they were injured in the course of their work. Staff members were encouraged to complete a self-care awareness assessment and there was an external employee assistance programme place.

Standard 6.4 - Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

There was evidence that there was a focus on continuous professional development in the centre. With the exception of one staff member who had been on extended leave all the team had all received training in the model of care in use across the organisation. Training was provided in child protection, a recognised model of behaviour management, first aid and fire safety. The management team had taken steps to ensure that was an awareness of organisational policies and procedures, relevant legislation and national standards among the staff team. There was a training needs analysis and a resourced training plan in place for the coming year. Staff were supported and expected to attend scheduled training. Required refresher training took place within the stated timeframes. The organisation had a pool of in-

house trainers in support of the staff development programme and a wide range of supplementary training was provided in support of the work.

There was a policy in respect of new staff being inducted to work in the organisation and the centre. This was evidenced as having been completed on individual personnel files. New staff completed shadow shifts with experienced members of the team before starting full time. An excel database was in place to record and track all training and professional development.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1** **Standard 6.4**
Practices met the required standard in some respects only	**Standard 6.2** **Standard 6.3**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must revisit the code of conduct and staff appraisal system with the staff team to ensure absolute clarity.
- The director of service must ensure that supervisee training is provider to the staff team.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The director of services must ensure that the centres admission policy document and the centres statement of purpose is updated to include the rights of young people, national standards and requirements of regulations and legislation.	The director of services has appointed a working group to review and complete TerraGlen's policies and procedures. The centres admission policy will be completed by May 22nd 2020 which will include the rights of the young people, national standards for children living in residential care and the requirement of regulations and legislation. In addition to this social care manager in consultation with the director of operations and director of services will complete the statement of purpose by Friday 1st of May. This will be communicated to the social care team at staff meeting on 6th May 2020.	The director of services has developed a working group for the review of TerraGlen's policies and procedures. Date of completion is September 2020. Unit managers and senior management are working collaboratively to ensure all policies are reviewed in advance of the deadline. Upon completion, the social care manager will deliver to all the social care team to ensure policy is understood and adhered to via management meetings, house team meetings and supervision.
	Senior management must ensure that communication and planning issues between allocated social work	A planning meeting took place with allocated department on 23/04/20. All parties agreed to a robust care plan to support this young person in their	Senior management to continue oversee the communication and planning for the young people and the staff team. This will be monitored and communicated from social

	department for one young person and the staff team are addressed collaboratively to ensure effective implementation of the goals of the care plan and placement plan. The centre manager must ensure that the Health and Safety statement is reviewed, updated and communicated to all staff.	placement. The social care manager continues to update the director of operations and director of services on the care planning of the young person via email and the weekly governance report. The social care manager is currently reviewing the Health and Safety Statement in consultation with director of operations and director of services. This statement will be completed by 28/04/20 and delivered to social care workers at the team meeting before 20/05/20. All social care workers will be requested to sign and date that they have read and understood the information outlined in the statement and the importance of adhering to same in their daily practice.	care manager to director of operations and director of services via the WGR and supervision. If an issue should arise senior management will request an emergency CICIR to facilitate effective planning. The Health and Safety Statement was completed 28/04/20 and will be rolled out across the service from the 29/04/20. The Weekly Governance Report will ensure oversight by the social care manager, director of operations and director of services.
6	The centre manager must revisit the code of conduct and staff appraisal system with the staff	The social care manager has addressed the code of conduct policy with staff at a team meeting on 9.4.20 This was addressed also	The social care manager will ensure that social care workers are adhering to the code of conduct policy in their everyday practice

	team to ensure absolute clarity.	at bi- monthly management meeting and individual supervision with staff members to ensure clarity. The social care manager has addressed the purpose of the appraisal system with staff members at handovers, appraisals, and individual supervision to ensure absolute clarity.	of work. The social care manager will ensure oversight of the application of this policy in the weekly governance report which is submitted to the director of operations and director of services each Monday.
	The social care manager must ensure that supervisee training is provided to the staff team to comply with requirements of the National Standards for Children's Residential Centres 2018 HIQA.	Due to the recent pandemic of COVID 19 and in order to adhere to social distancing as per recommendations of the HSE; the director of services is currently developing a training course for supervisee training via a social media platform on May 21st.	The director of services oversees and completes the training schedule for TerraGlen and will ensure that all staff are in receipt of the required supervision training. Supervisee training will be incorporated into the training schedule as part of the core training for commencing employment in the organisation.