An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 050

Year: 2019

Inspection Report

Year:	**2019**
Name of Organisation:	**Home Again**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Dates of Inspection	**3rd and 4th of December 2019**
Registration Status:	**Registered without conditions attached 28th February 2020 to 28th February 2023**
Inspection Team:	**Eileen Woods** **Lorraine Egan**
Date Report Issued:	**21st February 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 28th of February 2002. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from the 28th of February 2017 to the 28th of February 2020.

The centre was registered to provide care for up to five young males, aged between thirteen to eighteen, on a medium to long term basis and there were four young people living at the centre at the time of the inspection. The centres model of care was described as based upon a therapeutic and relational child centred approach.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 4th of February 2020 and to the relevant social work departments on the 4th of February 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 11th of February 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: 050 without attached conditions from the 28th of February 2020 to the 28th of February 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The director of care completed a review of the child protection and safeguarding policies in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015. This was completed at the end of 2019 but the document is undated and is not in a tracked system for ongoing versions and reviews. The child safeguarding statement was up to date, displayed, available to all parties and had been reviewed, it was deemed compliant by the Tusla run child safeguarding statement compliance unit.

Inspectors found that the centre had a range of policies and procedures in place to support the team in protecting the young people from risk and unsafe situations and all forms of abuse and neglect. These were developed in line with the relevant Children First: National Guidance for the Protection and Welfare of Children 2017. The policies included the up to date child safeguarding statement, child protection reporting, safeguarding of vulnerable persons, complaints and risk management procedures. There was an anti bullying policy in place and inspectors found that the team integrated awareness of group dynamics into their daily work and acted to intervene where concerns were arising. There was an ethos of equality, respect and community that was actively promoted within the centre, the young people told inspectors about their sense of safety within the centre. Social workers also echoed this assessment of safety at the centre.

There was evidence of significant work taking place around day to day safeguarding for young people. The files and interviews recorded levels of escalating actions being implemented reflective of risks that young people were engaged in or exposed to. Leadership was evident from the manager and the staff demonstrated their insight and practice ability in safeguarding to a good standard. There was collaborative work with the allocated social workers and where possible directly with family members.

The young people's files contained individualised safety and behaviour management plans that had been updated in a manner and timeframe reflective of their risk profile. There were also records of meetings and conversations with the relevant

young people about their choices and how these were impacting on their daily lives. The young people's comments and responses were recorded and those young people who responded in writing and in person to the inspectors indicated that they trusted staff to help them raise something if it bothered them in the group.

The team had completed the required Tusla E-learning module: Introduction to Children First, 2017 and had completed additional training in child protection in January 2019. Inspectors found that working practice was overseen by the manager but that the policy and procedure knowledge base on the team was not good. Inspectors found that a specific training session must be completed with the team on their suite of child protection and safeguarding policies.

There was a protected disclosures policy, a code of professional practice for staff and a 'whistle blowing: A responsibility to speak out' section for staff which outlined the function of protected disclosures and the centres policy and procedure to follow. Inspectors found that the staff were aware of the pathways to raise concerns available to them.

There are arrangements in place to notify families or guardians of any incidents or allegations; this involves discussion and agreement with the allocated social workers for the young people.

Standard 3.2

The centre operated from a long established and well supported model of care incorporating therapeutic care for young people through a child centred relational approach utilising day to day working approaches that were positive and solution focused. The four young people spoke to or gave written feedback to inspectors and they strongly indicated that the young people found the staff available, non judgemental and helpful. The social workers for the young people found that matters around behaviours and emotions were respectfully and openly addressed with the young people.

The team and the management were clear about the approach and supported this through the policies and practices, the team meetings and the additional specialist advice and consultation available to the team. There was training provided that complemented the approach and a new specialist consultant with a trauma and attachment informed focus had begun monthly sessions with the staff team.

The team were also trained in a recognised model of behaviour management and this set alongside the model of care in daily practice. There were plans on file for all the young people to support the staff in how best to respond to and manage harmful behaviours if presenting for a young person. They also had plans in place that responded to and tracked emotional and psychological issues emerging for the young people. There was specific key work and individual work undertaken with the young people around challenging behaviour. There was additional complementary training in suicide awareness. Issues of concern were tracked and followed up through the use of a significant event report by the manager to highlight escalating concerns whether in mental health or in child safeguarding.

The director of care audited the practices through file review, receipt of reports, review of significant events, attendance at team meetings and observations and stated that they were happy with the quality and professionalism of the work at the centre overall. The director was the sole undertaker of auditing for the centre and had yet to fully establish a quality assurance system fully geared toward the new standards and the legislation. The director and the manager had commenced discussions towards this.

At the time of the inspection there were no restrictive practices in place at the centre. There was also a policy commitment to the non use of physical restraint and there had been none at the centre. There was an awareness that should a restrictive practice be considered that it would only be through risk assessment and collaborative professional decision making. There was also an awareness that thereafter it would have to regularly review with a view to minimising the time frame.

Standard 3.3

Inspectors found evidence in practice where young people had raised matters concerning them and that these had been responded to. The staff team also stated that under the existing management structure that there was accountability and also an opportunity to safely discuss practice and raise concerns if they had any. No concerns were raised with inspectors during this inspection visit. Where appropriate young people were supported to make a formal complaint, records of these were maintained on file and noted in a register.

Inspectors found that there was a policy and procedure in place regarding significant events that was known and implemented in practice by the team. There was evidence of incidents being reported in a prompt and clearly expressed manner using a secure

means. There was commentary and follow up from the manager and from the staff. Families, guardian ad litem and socials workers were kept informed verbally, in writing and meetings were convened to agree actions. The responses put in place were routinely reviewed thereafter until the issues were resolved, the follow up for individual young people involved the relevant persons, in particular social workers. Overall inspectors found that the incidents being reported informed the work at the centre and interventions were actively reviewed at team meetings and in supervision.

The director of care had arrangements in place to attend a regional significant event review group and the manager and staff stated that some feedback was provided from this. Inspectors recommend that the manager and staff move toward a significant event review group that allows them to document meaningful incident monitoring, review and feedback to inform practice. The manager had strengthened the follow up around individual incident trends emerging for young people and a group review could look at staff practice in line with the model of behaviour management in use.

Inspectors found that there was no dedicated mechanism in place as yet that allows the director of care to formally gather feedback from families, social workers and significant others. The director of care must put in place a formal recorded mechanism through which to seek feedback that can support future development within the service. There was communication and discussion on an ongoing basis and collaborative work which allowed the manager at the centre a means to measure views on a day to day basis and to respond accordingly.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The management must arrange training for the team in the revised suite of policies and procedures underpinning child protection and safeguarding at the centre.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The director of care for this voluntary body oversaw all areas of responsibility for the management of care delivery in compliance with the national standards, the relevant regulations and legislation. The policies and procedures, information for young people and for staff including access to resources were in place but not up to date in all areas at the time of the inspection. A full review of the policies and procedures was ongoing at the time of the inspection and were received by inspectors in the weeks after the onsite visit. There was a board of management in place with sub committees and the board approves all new and revised policy documents. The centre manager is the designated person in charge of the centre and reports to the director.

Staff in the centre demonstrated knowledge of the voluntary body structure, its purpose and their role as part of this. There was evidence that the manager was overseeing that staff worked within policies and procedures appropriately although named during the inspection that up to date reviewed policies and procedures were required without further delay for the centre. Inspectors found that through questionnaires and interviews that staff had sound working knowledge of the model of care and of safe care and protection for young people, they did not however have ownership of the detail of legislation and how it related to their day to day policies and therefore the link to their practice. There was also evidence that staff required focused additional training and review of their child protection and safeguarding policies and procedures to ensure that all had an equal level of working knowledge. Inspectors advise that there be a closer connection and feedback mechanism for staff in the areas of policy development and outcomes for practice, for example, through significant event review groups or similar.

Standard 5.2

Inspectors found that the manager as the designated person in charge of the centre displayed leadership of the centre staff team through daily presence, team meetings, supervision and support of the staff and the young people. They also were named by the social workers as being involved in key risk management and decision making regarding the young people. It was named by professionals that communication routes and flexibility was at a good standard with the centre.

The staffing structure in place at the centre included a manager, two and a half team leader posts and nine social care workers and additional relief. Arrangements for who deputises for the manager were named in the policy document. The manager meets with the social care leaders on a monthly basis and supervised them. There were clearly delegated tasks assigned to all the internal management team and these were addressed operationally through this monthly meeting, records were available of these. A monthly governance report was completed and submitted to the director of service. The manager reported through the monthly mechanism to the welfare committee of the Board of Management. The committee met monthly and the manager had met with the committee.

The director audited thematically and identified actions for the manager to respond to. There was evidence of the manager structuring their responses and looking to further enhance the evidence based quality assurance systems within the centre. Some of the internal management and quality assurance and compliance processes were relatively new and under active review by the manager and the director for effectiveness. Both were aware that ongoing development was required to continue to bring the centre into line with the new national standards and relevant legislation.

The director was based at the property and attended some handovers and team meetings. They sampled files and spoke to staff and young people on an ongoing basis. They utilised observations as well as review to inform their oversight of the work. They were satisfied with the recent development in practices within the centre and the standard of care of the young people. An area that they acknowledged requires attention in the coming phase of the centres development is the upgrading internally of the property.

There was a service level agreement in place between the voluntary body and the funding body, The Child and Family Agency. The matter of adequate funding levels to maintain suitable levels of cover to meet the needs of the young people in a safe and responsive way was an ongoing discussion issue with regard to service level agreements. Inspectors found that the centre has invested in continuous improvements and remains committed to high quality care delivery for young people. The director produces an annual report which is made publicly available by the organisation and was provided to the Child and Family Agency.

The centre has a risk management procedure which gives the outline of the risk management practices that inspectors found were actively in operation. There were risk assessments and safety plans which were collaboratively reviewed with

professionals and family members where the threshold was met for medium to high risk. The present policy could be expanded upon in time to reflect the full scope of practices and to accommodate the inclusion of a risk register for the centre.

Standard 5.3

There was an up to date statement of purpose for the centre and the evidence based model of care was well and clearly expressed within this in an accessible manner. The social workers were clear about the aims and ethos of the team and how this translated into practices day to day with the young people.

All the relevant aspects relating to staffing, care practices and consultation were outlined within the statement of purpose and the mission statement. The statement is available upon request and a description of the service was given to young people and their families where possible also. The centre and what it had to offer was reflected in care plan meetings, pre admission meetings and pre admission risk assessments and in subsequent meetings related to young people's well being. The community meetings held with the young people at the centre also highlighted and upheld the principles of care as identified within the model. The four young people let inspectors know that they were happy with how they were being supported and cared for.

The director stated that the model of care, purpose of the centre, its practices and outcomes were reviewed as part of an annual report and through the ongoing monthly reports. They also stated that a business plan was devised to continue to support the level of training and consultation currently in place as there was evidence that it benefitted young people. Inspectors found that the staff clearly understood and delivered the model of care in their day to day practices.

Standard 5.4

Inspectors found that there were some internal systems already established in practice from the director level to assess on an on-going basis the quality of care provision, to analyse staff practice and review outcomes for young people. These included centre manager reports to the director, some audits of files by the director and presence at meetings, handovers and contact with young people and staff by the director to the centre. There were good records of well attended team meetings that took place on a fortnightly basis with every second one being dedicated to a consultation session with a specialist with expertise relevant to the model of care.

This has been maintained with consistency and continuity and has been funded by the board throughout the development of the centre.

The director attended some team meetings and was confident that these meetings and others within the centre reviewed updates for young people, safeguarding concerns and the general business of the daily practice requirements at the centre. There was a new focus on the young people's community meetings from the manager's perspective and they were introducing a refreshed group living approach to include more community meetings, groups outings and activities. The director and the manager presented as both working in a clear, direct and recorded manner toward service improvements.

The policy and procedure document detailed the Board of Management arrangements and responsibility to oversee that the centre meets its strategic, statutory and financial obligations. The director of care provided monthly reports to the Board of Management and whilst, as stated, they did have a system of thematic internal audit in place there is evidence that this should develop further to assessing and benchmarking against the National Standard for Children's Residential Centres, 2018 (HIQA).

Inspectors found that at team meetings, internal management meetings and in reports to the director that there was information relating to complaints, and tracking of concerns and incidents. The manager took leadership on these and acted to highlight escalating risks or unresolved issues. The director then had oversight of the actions and outcomes.

The annual report generated by the director looked at the whole voluntary body and had been informed in part by discussions with the manager internally regarding specifics for this centre.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.2** **Regulation 6.1**
Regulation not met	

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

Actions Required

- The director must establish a quality assurance system geared toward the new standards and the relevant legislation. They must also develope formal mechanisms for gathering external feedback.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The management must arrange training for the team in the revised suite of policies and procedures underpinning child protection and safeguarding at the centre.	Revisiting of Child Protection and Safeguarding Policy will occur at team meeting 20.04.20. To ensure all staff understand how their working practise connect with updated policies and procedures.	Policies and procedures are an agenda item at team meetings. Revised policies and procedures are being rolled out this year through team meetings and in staff supervision sessions.
5	The director must establish a quality assurance system geared toward the new standards and the relevant legislation. They must also develope formal mechanisms for gathering external feedback.	Centre Manager will develop a plan of action from inspection report with new Director upon their commencement of the role (April 2020).	Monthly management meetings between Centre Manager and Director to review Governance and quality assurance systems.