An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 060

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Terraglen Residential Services Ltd**
Registered Capacity:	**Two**
Type of Inspection:	**Themed Announced**
Date of inspection:	**06th & 07th of July 2020**
Registration Status:	**Registered without attached conditions 13th August 2020 to 13th August 2023**
Inspection Team:	**Eileen Woods** **Orla Griffin**
Date Report Issued:	**11th August 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 13th of August 2014. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from the 13th of August 2017 to the 13th of August 2020.

The centre was registered to provide care for two children and young people aged twelve to eighteen years on a medium to long term basis. The model of care was described as relationship based adapted from pro-social modelling and attachment theory. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors 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 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 review inspection was carried out remotely. This inspection was carried out through a review of documentation and a number of telephone interviews.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 24th of July 2020. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 10th of August 2020 and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 060 without attached conditions from 13th August 2020 to 13th August 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulations 5: Care Practices and Operational Policies
Regulation and 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 directors of the service had updated the centres policies and procedures in line with the National Standards for Children's Residential Centres, HIQA, 2018 and with reference to relevant legislation and guidelines. This document was finalised on the 9th of June 2020 and was being prepared for printing and circulation. Inspectors received a digital copy for review. The manager had been part of the development of the policy document and specific policies updated in response to the November 2019 inspection had already been part of team internal training in February 2020. Inspectors also found though that follow up training on the child protection and safeguarding policies and procedures agreed for completion with the team for February 2020 had been deferred due to the initial response to the pandemic. This must now be completed with the team.

Inspectors found that the reviewed policy document was comprehensive and structured in line with the national standards. Areas of expression or points of reference observed during the inspector's review were highlighted to the directors and considered for updating on the document, they completed these items before the issuance of this draft report. The senior management team had a plan in place to deliver training and induction into these once printed. The manager and the staff demonstrated that they were working in accordance with the policies and had good overall knowledge of the procedures and model of care that most guided their day to day work. Inspectors did find that there were specific areas requiring focus regarding broader team knowledge and these included restrictive practices, protected disclosures and code of conduct.

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-cantered, safe and effective care and support.

The centre had policies on leadership and management, clinical governance and internal auditing procedures and inspectors found that structures and work practices were in place in line with the policies. The policies were appropriate to the governance requirements of the centres purpose and function. As stated the policies and procedures were fully reviewed and restructured in line with the national standards for children's residential centre, HIQA, 2018, the centre management were involved in this process.

Inspectors evidenced there was a clear management structure in place, roles were identified and staff demonstrated clear knowledge of each person's professional role and responsibilities within the organisational structure of the company. The staff named that they had access to training, feedback from audits and they displayed a shared purpose on pursuing good outcomes for young people. Inspectors found evidence of a culture of ongoing development and system of continuous improvement. This was captured at team level in supervision, training schedules and team meetings. At senior level this was captured through the Quality Improvement Plan, March 2020, the bi monthly audits, management meetings and communications between the parties.

The centre had a previously agreed contract with Tusla for the provision of a service as identified in the agreed statement of purpose. The tendering process was ongoing by Tusla and the centre was part of the process.

Inspectors found that the manager, as the person in charge, had remained in post since the last inspection and provided continuity in the internal management structure for the centre. The management team included a suitably qualified and experienced deputy manager. Inspectors confirmed through review of records and in feedback from staff that there was leadership provided for decision making and that the centre management were available to staff. The staff knew the roles of directors, their governance role and how this would be executed at the centre. All members of the team stated that they had job descriptions and were clear in interview and in questionnaires about their day to day role including when key working. The team identified that they all had a role in weekly accountability for practice. A young

person let inspectors know that they found the team and management to be open, fair and hard working.

The centre had a risk assessment and management policy in place and the inspectors found that the staff had been inducted into the policy. They were implementing it in practice and this was overseen by the manager at centre level through document review, register review and discussion at team meeting and significant event review group meetings. Inspectors confirmed that the system of risk assessment and management was operational and included a procedure for escalation externally should that be identified as required. The policy also linked to how risk assessment at centre level would inform other behaviour management options and plans for young people. Inspectors found that due to Covid 19 that a review of restraints for the period March to May 2020 had not taken place and advised that this be completed. Inspectors also found that the staff although adapting to the internal risk management framework had limited knowledge regarding the escalation option.

The company had a dynamic 'interim health and infection prevention control information, guidelines and procedures on the prevention and management of Covid 19' document. During all stages of the response to the Covid 19 pandemic the directors had made staff aware of the arrangements and changes in place. There were Covid 19 related risk assessments and risk management plans for each young person, for staff daily work and the premises. Short term response actions such as manager off site work and longer shifts on the roster to reduce footfall were removed without undue delay.

The manager maintained a list of delegated tasks and the names of the persons with the assigned responsibility, there was also an on call system in place shared between the manager, deputy and the social care leaders. The directors were available as senior on call taking account of the additional needs around the ongoing pandemic response.

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

The statement of purpose for the centre had been updated in the preceding six months and the manager stated that the quality assurance practices included regular oversight of the statement and the centres operation in compliance with the practices as laid out in the document.

Inspectors found that the statement of purpose was developed in line with the criteria as laid out in the standards. The numbers of staff were suitable to the operation of the centre in line with its aims and objectives. The team were trained in the model of care and additional clinical support and guidance was being introduced by the company. The team referenced during their interviews and in their questionnaires the intended model of pro social modelling and gave concrete examples of how they implemented this day to day.

Once reviewed, the statement of purpose had been circulated to the allocated social workers to young people residing in the centre. The manager stated that they had sought feedback from families and social workers about the centre.

At the time of this inspection the operation of the centre in compliance with the updated statement of purpose had not been subject to external audit by the directors. This is planned to be included as part of the framework for bi-monthly auditing in due course. The operation of the centre in compliance with its statement of purpose should be assessed as part of the annual report processes.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

The manager and the team completed a weekly governance report to the director of operations who responded to the report with any observations, questions and tasks within three days. The director of operations quality assured the weekly reports through announced and unannounced visits to the centre, participation in significant event review, review of the risk assessment framework and team feedback. The directors jointly conducted bi monthly quality assurance audits against selected themes, regulations and statutory requirements. Once an external audit was completed required actions were identified within it and inspectors saw evidence of these being responded to by the manager and acted on within a set timeframe. The audit conducted in 2020 took place in June 2020 following disruption to the planned yearly schedule of audits during the initial stage of the national response to the pandemic.

An emergency strategy was implemented to adapt oversight during the pandemic utilising digital communication for meetings and oversight. The safety of staff and young people was given due regard through the creation and circulation of general

guidelines and procedures for managing Covid 19 and ensuring that all staff availed of relevant national training provided by the HSE for frontline workers.

Inspectors found that the staff had a focus on outcomes for young people and this was promoted through their policy documents, weekly and monthly reporting processes and by management. The reviewed policies and procedures further supported this outlook. The centre staff presented to inspector's evidence of progress made by the young people taking account of their personnel circumstances. Inspectors found that there was evidence of continuous systems in place to assess, review and improve the quality and safety of care provided to the young people.

Regarding internal oversight inspectors were provided with evidence of action taken by the manager to process complaints in accordance with the policy in place. The policy allows for an internal problem solving approach as well as a formal complaint procedure. In response to incidents and concerns there were risk assessments, behaviour management plans and notifications made when required. The significant event review group had been paused for a period during the pandemic and the inspectors advised that the restraints that occurred during that period must be reviewed for safety and practice outcomes. Inspectors found that for complaints, concerns and incidents that social workers were notified in writing and the social workers confirmed that families were verbally informed. There was evidence of the director of operations oversight on all complaints and incidents.

The external management records during the period of the pandemic did not evidence directly the type of recommended review and analysis of trends and learning arising from review of complaints, concerns and incidents in a cohesive manner as yet. Inspectors were informed that this type of review was underway as identified as part of the quality improvement plan. The external management must ensure that all staff are made aware of any outcomes from these to promote improvements and must organise for the completion of the renewed training in child protection and safeguarding agreed to for 2020.

The directors had implemented a quality improvement plan from which an annual review of compliance will be drawn. The plan had been reviewed by the Board of Management and the framework was robust, reviewed and included accountability for identified actions. The plan was informed by the weekly governance reports, self evaluations checklist and internal audits.

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

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 directors and the centre manager must schedule and complete the team training on the centres child protection and safeguarding policies and procedures.
- The centre manager must ensure that a significant event review group is held that reviews, for learning and outcomes, the restraints that have occurred at the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The directors and the centre manager must schedule and complete the team training on the centres child protection and safeguarding policies and procedures.	Director of Services will provide Child Protection Training to all the centre staff prior to the end of August 2020 on a schedule to accommodate the centre roster. Centre manager will monitor competence in team meetings and supervision.	All staff in Laurel Lodge will up to date with the child protection training by the end of August 2020. As new staff join the team Child protection will be in place as part of the Core training required to work with Terraglen residential services.
	The centre manager must ensure that a significant event review group is held that reviews, for learning and outcomes, the restraints that have occurred at the centre.	SERG Review Date: 11.08.2020. This SERG will specifically review the SEN's involving physical restraints and the ongoing SERG's will review the restraints used in the centre for reflective practice.	Review of restraints will be a main focus when Laurel Lodge are participating in the monthly Significant Event Review Group (SERG) ongoing and will be monitored by Directors.