An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 051

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Home Again**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Date of inspection:	**07th and 08th January 2020**
Registration Status:	**Without attached conditions from 28th February 2020 to 28th February 2023**
Inspection Team:	**Cora Kelly** **Lorraine Egan**
Date Report Issued:	**10th March 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 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 28th February 2017 to 28th February 2020.

The centre's purpose and function was to accommodate five males from age thirteen to seventeen on admission. Their model of care was based on a therapeutic and relationship approach derived from the Response Ability Pathways model. This directed that staff would engage in intentional interactions with young people that were expected to support positive outcomes for young people. There were two young people resident in the centre at the time of inspection one of whom was over eighteen years of age and was discharged from the centre in a planned manner on the second day of the onsite 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 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 centre manager, director of services and the relevant social work departments on the 4th February 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 18th February 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: 051 without attached conditions from the 28th February 2020 to the 28th 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 centre had a safeguarding and child protection policy that was last reviewed and updated in December 2019. The centre had a child safeguarding statement (CSS) that was approved by the Tusla Child Safeguarding Statement Compliance Unit. It now requires updating in response to the recent appointment of the acting centre manager who will be referred to as the centre manager throughout this report.

The director of services is both the named person and relevant person in respect of the CSS. The centre manager was the designated liaison person (DLP) with a social care leader as the deputy DLP. DLP training that had been provided to the centre manager must be secured for the deputy DLP. Contact details of the DLP's requires updating in the policy and procedures document. It was observed from the review of a sample of personnel files that staff were vetted in accordance with legislative requirements but the renewing of Garda vetting was not up-to-date. This was addressed with centre management during the onsite inspection who advised the inspectors that it was due to a delay by the director of services in submitting the required forms. The inspector can confirm that this issue had been rectified in the weeks after the inspection. The director of services must ensure Garda vetting is up-to-date for all staff employed in the centre.

A sample of safeguarding and child protection procedures in the policy included those for protected disclosures, complaints, whistle-blowing, code of practice for staff, rights of children and bullying. It was found from the review of the child protection concerns reporting procedures that they were not fully compliant with the Children First Act, 2015. The centre did not have a list of mandated persons as centre management deemed that all staff employed in the centre were mandated persons. From the inspector's review of staff qualifications, it was found that not all staff met the criteria required for mandated persons. This was addressed with the centre manager who submitted a list of mandated persons prior to the draft report being issued.

Staff had received training in Children First: National Guidance for the Protection and Welfare of Children, 2017 in early 2019 and on the Tusla E-Learning module: Introduction to Children First. It was found from the review of questionnaires and interviews there were deficits in staff's awareness and understanding of safeguarding policies governing their work. Also, mandated staff were not clear of their role to report child protection concerns.

Child protection and welfare report forms (CPWRF's) had not been submitted through Tusla Child and Family Agency portal since the last inspection. One CPWRF that was submitted in 2018 was found to have been outstanding. The inspectors recommend that the centre manager pursues with the relevant social worker until the investigation is concluded. The centre did not have a register for the recording of child protection reports or of concerns that did not meet reasonable grounds for concern. This was quickly remedied by the centre manager after the onsite inspection.

In conclusion, improvements are required with regard to the safeguarding and child protection policy and the implementation of the procedures outlined in the policy. The director of services must ensure that the revised safeguarding and child protection policy includes reporting procedures for those holding mandated and non-mandated responsibilities, that staff receive training on the revised document and that all procedures required to implement the policy are in place.

In general, there was a good awareness by staff on how young people were kept safe in the centre. Work was being completed by staff in addressing self-care and protection work with young people in line with their age, ability, and stage of development. Placement plans and keyworking referenced work in these areas. It was evident from the review of young people's files that staff worked in partnership with the families of the young people to promote their safety and well-being. Based on onsite observations, interviews and the file review it was clear that the young people had good relationships with the staff team.

It was evident from the review of young people's files that there was good communication between staff in the centre and young people's parents, families and allocated social worker. Processes in place included the above named being informed of incidents and allegations relating to the young people. In interview, staff were aware of the procedures for protected disclosures.

Standard 3.2

The centre had a behaviour management policy that was linked to the therapeutic and relational approach model of care. Staff were trained in a recognised model of behaviour management and had been provided with regular refresher training. Staff also received regular training on the model of care.

Staff in interview demonstrated a good understanding of how challenging behaviours were managed namely through keyworking. Topics such as bullying and substance misuse were approached in an age appropriate manner. This was also evident from the review of questionnaires and young people's files. The centre manager named the forums of handovers, supervision and team meetings as being the main conduits for keeping staff up-to-date on the young people's behaviours. Inspectors found that two types of behaviour management plans were held on the young people's files. The centre manager advised that the changes were currently taking place with regard to the behaviour management process. The inspectors recommend that the director of services oversees this process to ensure practices are aligned to policy.

It was clear from the review of records and staff interviews that positive behaviour was recognised, promoted and was an important aspect of staffs practice. Young people had individual crisis management plans where behaviours of concerns were named and included clear direction for staff in responding to behaviours presented.

The director of services, who held responsibility for conducting governance audits, monitored young people's behaviours and staff's management of same through their presence in centre, review of significant events and monthly manager reports. They had yet to audit behaviour that challenges.

At the time of the inspection the centre manager was actively addressing the single restrictive procedure that was in place for some time in the centre. A risk assessment had been completed and reviewing processes were scheduled in consultation with the staff team and young people for this particular case. The inspectors recommend that the centre manager also consults with the relevant social worker. This restrictive procedure was removed prior to the draft report being issued.

Standard 3.3

The procedures for responding to complaints were outlined in the centre's complaints policy. The forums for ensuring young people voices were heard included young people's meetings, child in care reviews, keyworking and the complaints system. The uptake of young people's meetings that were scheduled to take place weekly required improvement. The centre manager recognised this and will work towards improving these.

There were no outstanding complaints at the time of the inspection. Complaints that had been made since the last inspection had been managed appropriately in consultation with the young people and with external input.

The centre manager was aware that there were no formal mechanisms for parents, families or social workers to provide feedback. It was noted that input was provided verbally by parents and social workers through care planning meetings. The registered provider must ensure that there are formal mechanisms in place so that significant people in young people's lives can provide feedback and identify areas for improvement.

The centre had a significant event notification system (SEN) that included the notification, management and reviewing of incidents. Incidents were found to have been promptly reported to the relevant professionals. This was confirmed in interview with a social worker who also advised that the quality of the reports was good. The centre manager advised that incidents were reviewed internally with staff individually and at team meetings and by the director of services. They were further monitored through young people's placement plans to identify trends and patterns of behaviour. The centre manager must align the risk management framework to the SEN process to enhance best care practice for the young people.

The director of services was part of a regional Tusla significant event review group. Feedback to the centre manager and staff team was reported to have been limited. In interview the director of services spoke of developing a SEN group for the organisation to include two centre managers and two social care leaders. The director of services must ensure that a significant event review group is developed so that incidents are reviewed and that the staff team is provided with feedback on learning from the process.

Compliance with Regulation	
Regulation met /not met	**Regulation 16**

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

Actions required

- DLP training must be secured for the deputy DLP.
- The director of services must ensure Garda vetting is up-to-date for all staff employed in the centre.
- The director of services must ensure that the revised safeguarding and child protection policy includes reporting procedures for those holding mandated and non-mandated responsibilities, that staff receive training on the revised document and that all procedures required to implement the policy are in place.
- The centre manager must ensure that the risk management process is implemented in line with policy and that safety plans for young people are developed in response to risks assessments.
- The registered provider must ensure that there are formal mechanisms in place so that significant people in young people's lives can provide feedback and identify areas for improvement.
- The director of services must ensure that a significant event review group is developed so that incidents are reviewed and that the staff team is provided with feedback on learning from the process.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The director of services held responsibility for reviewing and updating the centres policies and procedures and ensuring compliance with the requirements set out in legislation, regulations and the national standards for children in care. They were last reviewed in December 2019. As advised by the director of services in interview with the inspectors the policies were, at the time of the inspection, not fully in line with the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First Act, 2015 and required further updating. A copy of the HIQA, 2018 standards document was available in the centre for staff to familiarise themselves with.

The inspectors found from the review of questionnaires and interviews that staff understanding of the National Standards, 2018 and also the centre's child protection policy and procedures was limited. The registered provider must ensure that the centre is fully compliant with the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First legislation, that the further review of the policy and procedures document is completed in a timely manner and staff are provided with training on the revised document. This will then complement the centre managers plan of reviewing and discussing the standards regularly at team meetings throughout 2020.

Standard 5.2

The centre's organisation structure was comprised of an executive committee, director of services, centre manager, social care leaders and social care workers. Since the last inspection in September 2019 there had been a change in centre manager. An acting centre manager, appointed mid December 2019 had only commenced the role on a full-time basis one day prior to this inspection in January 2020. The intervening period was to allow them to complete their duties as a social care leader. They had worked in the centre for 12 years and were appropriately qualified.

The centre manager was charged with overall managerial accountability, responsibility and authority for the delivery of the service in the centre. An external professional support being sought to assist the centre manager with this task. A detailed action plan had been developed to improve overall operational, governance,

management and care practices. This action plan also included responding to actions highlighted in previous Tusla inspection reports. The plan detailed those responsible for implementing actions within agreed timeframes. In conjunction with this mechanism the centre manager was committed to streamlining the centres systems and processes aligned to those established in the organisations sister centre. To date, the centre manager had established communication links with the centre manager in that centre with direction and support provided by the director of services. The inspectors recommend that the director of services formalises both of these support arrangements.

The centre manager demonstrated in interview a good understanding and knowledge of how leadership and governance will be provided in the centre. They outlined how their roles and responsibilities will be implemented on a daily basis for example attendance at handovers, ongoing presence in the centre, reviewing paperwork, chairing team meetings and monthly internal management meetings, conducting and ensuring the implementation of the supervision schedule and compiling monthly governance reports for the director of services and welfare committee, a sub executive committee.

The centre manager was supported by two social care leaders one of whom was appointed on an acting basis in the weeks following the onsite inspection, eight social care workers and relief staff. Given the significant amount of change that was taking place it was found from the review of questionnaires and interviews that staff were supportive of the centre manager and of the impending changes being made to strengthen care practices. The director of services advised in interview that discussions were taking place with respect to the roles and responsibilities of the internal management team that will include social care leaders acting up in the manager's absence. In line with centre policy the centre manager must ensure that written records are kept of duties delegated to social care leaders to include key decisions made. Arrangements were in place for internal management and senior management to meet monthly with the latter being expanded to include the centre manager from the organisations sister centre.

As alluded to earlier in this report the centre had a risk management policy. Prior to this inspection it was not implemented in practice. The centre manager, with the assistance of external support was familiarising themselves with the concept of risk assessment, identification, assessment and management of risk. A number of individual risk assessments had been completed in the days prior to the onsite inspection that were being introduced to the staff team at their next team meeting.

The centre manager must ensure that the risk management framework is fully implemented including the development of a risk register.

There was a service level agreement between the organisation and Tusla to which the director of services provided an annual report.

Standard 5.3

There was a statement of purpose that named the model of care as therapeutic and relational approach based. The aim, objectives, ethos and day-to-day running of the centre was included in the statement in addition to the supportive roles of management, staff and external consultants in providing care to the young people. The statement is subject to annual review by the director of services and was last updated in December 2019. External training on the model had been provided to the centre on an ongoing basis during 2019.

Staff in interview demonstrated clearly their understanding of the statement of purpose. They did however state that it was not always reflected in centre records and young people's files. The centre manager and director of services had identified this too. Recording mechanisms had been recently updated to now include the model of care as part of discussions at team meetings and within the supervision process.

The statement of purpose was prominently displayed in the staff office.

Standard 5.4

The director of services and the centre manager had individual roles and responsibilities to ensure that the quality, safety and continuity of care to the young people was regularly reviewed and assessed. In light of changes to centre management in the weeks prior to this inspection the overall governance system was in its infancy stage of implementation. While the centre manager was new to the role the staff team were experienced. The centre manager had yet to chair team meetings and internal management meetings, oversee young people meetings records, ensure that quality supervision was held, complete monthly governance reports for the director of services and respond to the centres governance action plan. A detailed schedule had been devised that accounted for the implementation of these governance and oversight tasks. To ensure that quality care will be provided to the young people on an ongoing basis the centre manager will maintain a presence in the centre, attend handovers and review centre records and young people files.

The director of services who visited the centre regularly, met with the centre manager monthly and was accountable to the executive committee. The inspectors found from the review of the management meeting minutes book that records were brief and did not record any detail relating to discussions held, decisions made and actions agreed. The director of services must ensure that detailed minutes of management meetings are held and that these are tracked monthly.

Responsibility for the completion of audits of operational and care practices was held by the director of services. The governance audit framework was not, at the time of the inspection, developed in line with the National Standards for Children's Residential Centres, 2018 (HIQA). The director of services must ensure that an audit tool based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed in a timely manner.

Complaints, incidents and concerns relating to young people were items for discussion at team meetings. They were not part of internal management or meetings with the director of services. The director of services must ensure that complaints, incidents and concerns are added to the agendas of management meetings to ensure they are regularly reviewed, monitored to identify patterns and trends and that learning is used to inform care practices.

An annual report had been completed by the executive committee in 2019. The director of services inspectors recommend that senior management develops a tool to annually review compliance with the centres objectives and that timely action is taken to promote improvements in work practices to achieve better outcomes for children.

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

Actions required

- The registered provider must ensure that the centre is fully compliant with the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First legislation, that the further review of the policy and procedures document is completed in a timely manner and staff are provided with training on the revised document.
- The centre manager must ensure that the risk management framework is fully implemented including the development of a risk register.
- The centre manager must ensure that written records are kept of duties delegated to social care leaders to include key decisions made.
- The director of services must ensure that an audit tool based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed in a timely manner.
- The director of services must ensure that complaints, incidents and concerns are added to the agendas of management meetings to ensure they are regularly reviewed, monitored to identify patterns and trends and that learning is used to inform care practices.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	DLP training must be secured for the deputy DLP.	The deputy DLP will attend DLP training on the 11th March 2020.	Through regular auditing and monitoring the director of services will ensure that those with safeguarding roles are provided with relevant training.
	The director of services must ensure Garda vetting is up-to-date for all staff employed in the centre.	Garda vetting is up-to-date with the exception of two. The renewing of Garda vetting for these staff members is in progress. It is hoped that these will be completed by 18th March 2020.	The director of services will monitor the renewing dates of Garda vetting on an ongoing basis. Reminder dates have been entered on staff personnel records to flag renewal dates.
	The director of services must ensure that the revised safeguarding and child protection policy includes reporting procedures for those holding mandated and non-mandated responsibilities, that staff receive training on the revised document and that all procedures required to implement the policy are in place.	The safeguarding and child protection policy will be updated by 18th February 2020. It will include reporting procedures for mandated and non-mandated staff. It will be brought to the attention of staff during supervision and they will be asked to read and sign the document. It will be brought to the staff meeting on the 4th March 2020 for discussion.	The director of services will review the all policy documents annually to ensure they are in line with legislation and that staff receive regular safeguarding training based on centres policy and procedures.

	The centre manager must ensure that the risk management process is implemented in line with policy and that safety plans for young people are developed in response to risks assessments.	The policy is currently being amended to reflect the current risk management process that is in place. This will be in place by May 2020. In the interim a guidance document will be developed and in place by the 28th February 2020. Staff will be informed of this at the team meeting on 4th March 2020. When needed safety plans will be put in place to address any risks identified for young people.	Through monitoring and auditing the director of services will ensure that the risk management procedures as outlined in policy are implemented. This process will include reviewing and monitoring personal support plans in place for young people including safety plans when deemed required.
	The registered provider must ensure that there are formal mechanisms in place so that significant people in young people's lives can provide feedback and identify areas for improvement.	The director of service and centre manager will develop a questionnaire to gather feedback and comments from young people's parents, families and social workers. Feedback will be considered in service improvement plans. This will be completed by the 6th March 2020.	The director of services and centre manager will act on feedback provided and liaise with family and social workers in responding to actions identified.
	The director of services must ensure that a significant event review group is developed so that incidents are reviewed and that the staff team is provided with feedback on learning from the process.	A significant review group has been established by the organisation where significant events from both centres will be reviewed monthly. The first of these meetings took place on the 6th February 2020. The minutes will be presented at the staff meetings for discussion and learning.	The director of services will ensure that these meetings occur as per schedule in place for 2020 and will review team meeting minutes to ensure that feedback is being provided. The director of services will in addition to this provide feedback to the centre manager on the Tusla led SERG

		Internally, SEN's will continue to be reviewed at staff meetings fortnightly to identify patterns and learning for the staff team.	meetings to ensure that learning is further enhanced for the centre manager and the staff team.
5	The registered provider must ensure that the centre is fully compliant with the National Standards for Children's Residential Centres, 2018 (HIQA) and Children First legislation, that the further review of the policy and procedures document is completed in a timely manner and staff are provided with training on the revised document.	The director of services is in the process of reviewing the policy document to ensure it is in line with the National Standards for Children's Residential Centres, 2018 and Children First Legislation. This will be completed by 1st April 2020. It will be available for the staff team to read and sign and will be brought to the staff meeting on the 15th April 2020.	The director of services will review the centres policies and procedures document annually to ensure it is in line with legislation, regulations and standards.
	The centre manager must ensure that the risk management framework is fully implemented including the development of a risk register.	The full risk management framework including a risk register will be fully implemented by the 15th March 2020. A guidance document is currently being developed and will be in place by the 28th February 2020.	Through monitoring and auditing the director of services will ensure that the risk management procedures as outlined in policy are implemented.
	The centre manager must ensure that written records are kept of duties delegated to social care leaders to include key decisions made.	Internal management meetings were formalised on the 3rd January 2020. The minutes' will outline duties delegated, persons responsible and timeframes for the completion of tasks.	The centre manager will ensure that internal management meetings take place fortnightly and all decisions and duties are reviewed.

	The director of services must ensure that an audit tool based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed in a timely manner. The director of services must ensure that complaints, incidents and concerns are added to the agendas of management meetings to ensure they are regularly reviewed, monitored to identify patterns and trends and that learning is used to inform care practices.	The director of services is in the process of developing a new audit tool in line with the National Standards for Children's Residential Centres, 2018 (HIQA). This will be in place by the 1st June 2020. The management meeting agenda was updated on the 5th February 2020 to include complaints, incidents and concerns. Identified patterns and trends will be brought to staff meetings to inform care practices and learning.	The director of services will ensure that from June 2020 all audits conducted will be based on the new standards. The director of services will ensure that complaints, incidents and concerns are addressed at management meetings and staff meetings.