An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 158

Year: 2019

Inspection Report

Year:	**2019**
Name of Organisation:	**Aspire Plus Ltd**
Registered Capacity:	**Three children**
Dates of inspection	**5th of December 2019**
Type of Inspection:	**Announced**
Registration Status:	**Centre closed 13/12/2019**
Inspection Team:	**Eileen Woods** **Anne McEvoy**
Date Report Issued:	**17th February 2020**

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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 25th of June 2019. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from the 25th of June 2019 to the 25th of June 2022. The first young person moved into the centre on the 17th of September 2019.

The centre was registered to provide community based medium to long term care for up to three young people aged between seven to twelve years old. The centres mission statement was "better days, better outcomes" through a strengths based approach and that an attachment informed model using ecological systems would be implemented. 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
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3

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 the allocated social workers and staff were provided with questionnaires. 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

This centre was registered to commence operations on the 25th of June 2019 and the first young person moved into the centre on the 17th September 2019. An inspection was commenced on the 5th of December.

The centre was found to not be in compliance with the statement of purpose and function under which their registration was approved. They were also not in compliance with the selected National Standards for Children's Residential Centres (HIQA 2018) and named regulations examined and detailed within this report.

An immediate action notice was issued to the registered proprietors by the registration service on the 9th of December 2019. The proprietors accepted the deficits in governance and they requested that the centre be removed from the national register of children's residential centres. No enforcement action was required by the inspection service following this. Centre 158 Aspire Plus Ltd has now been removed from the register on the 13th of December 2019.

Due to the Proprietors request to remove the centre from the register no issues requiring action have been issued with this report.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The registered proprietor did not ensure that this residential centre was operating in compliance with the relevant policies as outlined in Children First and in their child safeguarding statement. Inspectors found that the identification of what constituted a child protection concern was not competently displayed in practice. The records and tracking of child protection and welfare report forms submitted had been attended to for one young person but not for the other young person. The child safeguarding statement displayed at the centre was not the accurate version that was deemed compliant by the Tusla child safeguarding compliance unit. Inspectors were supplied with the correct version upon request and this must now be displayed at the centre.

One of the registered proprietors was able to verbally update the inspectors that allegations against staff had been addressed in line with the centres child protection policy and investigated by the social worker for the young person. This was confirmed by the investigating social worker involved. The records of this were not on file, the allegations were not contained on the register and the team were not able to locate the records at the centre upon request.

There was no evidence of tracking, oversight or audit of emerging child protection concerns, there was a lack of evidence of consistent leadership and a lack of appropriate external oversight from the outset of this centres commencement. The team meetings did not address child protection, there were no preadmission risk assessments or collective risk assessments on file to address the management of the known safeguarding concerns. There was no distinct safeguarding record of accumulating self harm statements. Some records of notifications related to disclosures recorded the parents/guardians as being notified by text message.

An allegation made between the young people was not evidenced as being reported to one child's social worker; also specific incidents related to assaults between the young people had not been fully mutually reported. Inspectors found that there was evidence that action needed to be taken ensure that access to the internet is protected

appropriately taking account of age and ability. The team must also ensure that there a fire drill and induction into fire safety is completed at the centre with the children and the staff.

There was insufficient evidence emerging in this new centre of focused work by the team on the group dynamic and impact, the individual safeguarding needs or on the ability of the children to start developing an awareness of their own safety. There were children's meetings in place but no traceable actions around the responses to matters raised in this. There was some evidence of working in partnership with social workers and families but this was also impacted by a lack of cohesive or available records for inspectors to review.

One of the registered proprietors named that the centre had a whistle blowing policy and code of safe practice but that when issues were arising at the centre they identified that staff had not utilised the procedure and named this as an issue they will urgently address with the team. The inspectors did not find a whistle blowing policy contained within the main policies and procedures document and this should be included within this also. Safeguarding issues identified by the registered proprietor following information they received and noted through a visit to the centre included poor records, incidents involving complaints from neighbours, the condition of the property and the furnishings/ resources for young people.

Standard 3.2

There was no overall cohesive sense of a therapeutic care model and appropriate supports in the plans and documents reviewed by inspectors. The records presented a lack of understanding as to how to show leadership on therapeutic care. The company had a psychologist in post for two hours a month and their input was evident on one file but not the other. There were no preadmission planning and risk assessment documents on file for inspectors to review so it could not be discerned fully what the care goals were to be. The placement plans were a lengthy format and for one child this was still partially completed and did not contain evidence of oversight or specialist input. The other young person's records were better quality in all aspects but lacked named persons identified to complete tasks. Following a review of the files the inspectors could not identify who the named key workers were. The key work folder for one child indicated that this had not commenced as yet they had been resident for one month at the time of the inspection.

The second young person had records of individualised planned and opportunity led work taking place with them. There were behaviour support plans on file that had been reviewed but not on all occasions named as required. The behaviour plans did not reflect the advice and findings of the specialists involved with the young people.

There was also a folder of guidelines in place for each of the two young people. These did not take account of the specialist reports; the psychologist input was not clearly defined and in some aspects presented as behaviour modification focused which was not in line with the stated strengths based approach.

The registered proprietors had plans in place to start structured audits of the quality of care and had consulted with external persons regarding same. It is now a priority that appropriate auditing be implemented. Both children had diagnoses that had implications for behaviour, mood and presentation and inspectors found that their administration of medications and medical section of the files needed to be significantly improved and co-ordinated to ensure safety. There must be consultation with a doctor regarding guidance for the use of restraint in respect of the medications involved and a risk assessment and risk management plan put in place around this.

There had been a number of restraints and physical interventions used with one child in particular. Non routine interventions were not listed as such in the dedicated section of the reporting form. Inspectors counted circa ten instances of the use of restraint and physical intervention with the child. There was some evidence of follow up with the child but there was little evidence of follow up commentary, actions and outcomes for practice. Therefore the emotional support for the child and the learning for the staff could not be verified. There was no evidence of external oversight. In copies of management meetings reviewed after the inspection there were no reviews of restraints recorded.

No evidence was presented of reviews of significant events although it was recorded that on call managers were consulted with during critical incidents. Management meeting records highlighted that this was a goal to be introduced in the next stage of the centres development but no date had been recorded for commencement. From the manner in which the records of significant events were created it was not clear to inspectors if a social worker or a family member would be aware of the number of restraints that had taken place per incident or overall. This must be followed up, there was a register of restraint in place but it was not accurate. There was no evidence of tracking of restraints conducted, no evidence presented of review of these through debrief with staff or through follow up for the child. The records did not

record if medical advice had been sought to clarify the safety aspects of the use of restraint with a child with a medical condition who takes daily medication. The records did not state if a young person or child was offered the complaints system or medical assistance after restraints.

Standard 3.3

A young person spoke to inspectors a number of times during our visit to the house and they indicated that they could bring up a concern of they needed to and that they knew who the manager was and who the director of services and the managing director were. The young person said they felt safe and that staff listened to them. The culture at the centre did not though present overall as one in which, as yet, that staff were encouraged to raise concerns or to identify areas for improvement.

The general register of significant events was newly created; the previous record was not available for inspectors to review. The combined register did not contain any entries on restrictive practices, rewards, consequences, complaints or medical as defined by their categories. The section on child protection within the combined register was not completed and the structure of it must improve along with the content. One child had varied counts of four, eleven and fourteen significant event notifications depending on which aspects of files the inspectors reviewed. There was lack of direction noted around notifications regarding follow up both for behaviour management but also regarding aspects of editing, for example timeframes of p.m. versus a.m.

It was not always clear on the reporting form if the directors were notified for each event. The daily log was similarly not accurate as a cross reference tool to ensure that safe reporting was taking place. There was no evidence presented that review and learning had taken place to inform a co-ordinated safe response. Standard documents such as the joint protocol missing child from care plan had not been completed and signed with the social workers. The centre had their own absence management plan on file which did note the risks involved but should have both in place. It was named to inspectors that one family had identified incidents to a social worker that they had been informed about by their child and not by the centre.

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

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

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

There were three registered proprietors of this company, one acted as managing director, another as a part time director of service along with one other proprietor. They were involved in on-call supports. There was some evidence of the director of service visiting and completing oversight of daily logs but no effective fit for purpose governance model had been implemented in full. Therefore the proprietors had not yet initiated a system by which they could evaluate if the centre was operated in compliance with the relevant regulations and legislation.

The proprietors had developed policies and procedures and recording systems for the centre and these were in place. They had also finalised an approved child safeguarding statement with the relevant compliance unit as stated. They had initiated management meetings, inspectors are unaware of the intended frequency for these but three were recorded as taking place in November in response to emerging need.

Standard 5.2

Inspectors did not find, based on the inspection, that leadership was evidenced within the residential centre in an even and consistently maintained manner. The culture initially established within the centre did not promote accountability and shared responsibility. The proprietors had steps in place to increase and implement

governance arrangements but these should have been in place from the outset given the challenging nature of the placements being undertaken by this new service.

The management structure at the centre was three registered proprietors, a manager, a deputy and eight staff at the time of the application for registration in June 2019. At the time of this inspection visit in December 2019 the inspectors found that a new manager and a new deputy had been identified over the preceding two days. The managing director and the director of services had some communication with the inspection service in the lead up to these changes. The inspection service had previous contact, in November, with the proprietors following the receipt of unsolicited information. Along with the changes in manager and deputy the inspectors identified approximately six additional changes to the staff team. The centre had applied for a change to their registered capacity from two to three since they opened.

There was a folder at the centre marked 'management' that provided staff with checklists and general staff guidelines on cleaning, sharps and general health and safety related areas. One of the registered proprietors had identified a number of issues related to the condition of the house at times and items within that had come to their attention after the fact. They visited the centre following the receipt of information related to internal practices and following complaints from neighbours. They directed action on some immediate items that were brought to their attention. These actions were not reflected on files available at the centre for review. The inspectors were provided with management meeting records after our onsite visit and these addressed some of the issues arising during November. The proprietors and management have supplied all records requested of them by inspectors.

A second folder marked' house management' had two internal centre management meeting records with the most recent being 23/9/2019. There were supervision schedules on file but completed supervision records were not present in hard copy at the centre to review for the staff team. The previous manager had received four supervision sessions by external supervisors since May 2019 and inspectors reviewed copies of these. Latterly the manager had been identifying a need for additional governance supports for the centre.

Inspectors did not find that the intended risk management structure was operational within the centre, beginning with pre admission records and onward. The records of team meetings were minimal and did not display safeguarding, risk assessment and risk management to a good standard. Risk management strategies had not been

reviewed in line with incidents and risk assessments such as, for example the removal of fire extinguishers from their designated locations was not on file. Significant threats to harm and assaults between young people was not reflected on updated risk assessments, plans or at meetings. There was evidence of a number of meetings with the company psychologist regarding one young person and as stated there was evidence of individual work being completed with them related to their identified areas of need and this indicates an area to be built upon by the staff in organising their work for the future.

There was no evidence recorded in the team meetings of discussion on placement plans, behaviour support plans, social work direction or the psychologist's advice. Although there were records of young people's meetings it was not clear how they were responded to and if action took place on foot of these. Key changes in staffing/personnel were not identified or noted for the records either. One record of a team meeting contained unclear notes regarding possible discussion of young people outside the unit and the proprietors must investigate this.

Standard 5.3

The centres statement of purpose and function was displayed in the office. This stated that alongside the strengths based approach that an 'attachment informed model using ecological systems' would be implemented and this did not communicate itself across the files reviewed. At the time of the inspection the day to day operation of the centre did not reflect the statement of purpose and function in the planning, the range of services nor the arrangements for safety and progression for the children.

There was no register of young people in place and on the files provided for review it could not be determined how the placements were determined as suitable for either young person. There were no pre admission or collective pre admission risk assessments presented on the files.

The age range for placements was aged seven to twelve years old and both had moved into the centre within that age criteria. The levels of staffing committed to in the statement of purpose had been maintained at the centre. Both social workers had identified areas for improvement required within practice at the centre and positives also. Both were satisfied for the placements to continue at that time and were engaging with the centre regarding improving planning and reporting.

Standard 5.4

The inspectors found that although present from time to time and taking action where alerted that the proprietors had not as yet implemented formal review mechanisms that assisted them in quality assuring the quality, safety and consistency of care at the centre in line with the purpose and function and policies and procedures. The previous manager had identified gaps in external organisational governance and systems in October during their external supervision but inspectors did not see additional records of a response to this.

They must co-ordinate a response that now fully audits the files identifies all serious incidents, restraints, self harm, safeguarding and child protection matters. They must initiate and oversee that suitable team meetings, supervisions, significant events reviews and restraint and restrictive practice reviews take place. They must monitor continuously, until satisfied, the flow of good quality information to and from staff and to and from children. They must monitor planning and care delivery at the centre and act accordingly to promote and support compliance with best practice, the national standards, legislation and relevant regulations.

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

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