An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 166

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Harmony Residential Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced Themed CAPA Review**
Date of inspection:	**24th March 2022**
Registration Status:	**From the 12th of April 2020 to the 12th of April 2023**
Inspection Team:	**Janice Ryan** **Ruth Coakley**
Date Report Issued:	**14th June 2022**

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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 and Regulation 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 monitor 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 current registration on the 12th of April 2020. At the time of this inspection the centre was in year two of the cycle. The centre was inspected in October 2021 and following the findings of that inspection it was registered with an attached condition from the 12th of April 2020 to the 12th of April 2023. That condition being:

- The corrective and preventative action plan is to be fully implemented so that the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 5, *Care Practice and Operational Policies*.

The condition was due to be reviewed on or before the 31st March 2022. The purpose of the inspection on the 16th of March 2022 was to review the Corrective and Preventative Action Plan (CAPA) in full and make a recommendation with regard to the attached condition.

The centre was registered as multi occupancy unit to provide care and accommodation for up to four young people aged between 16 and 17 years of age in order to prepare them for leaving care. Their model of care was described as informed by a therapeutic based approach of cognitive behaviour therapy that focused on the total behaviour of the young person. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior

management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 05 May 2022. 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 17th May 2022. The findings of this report and assessment by the inspection service of the submitted action plan were used to determine the centre's compliance and adherence to the regulatory frameworks and standards in line with its registration.

It was the determination of the Registration Committee that the centre has now met the requirements of the Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 5, *Care Practice and Operational Policies*. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 166 without attached conditions from the 12th of April 2020 to the 12th of April 2023 pursuant to Part VIII, 1991 Child Care Act.

Subsequent to this inspection the registered proprietor provided evidence that they had come into compliance in relation to Regulation 7, Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 7, Staffing.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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-centred, safe and effective care and support.

The service had appointed a new acting social care manager on the 14th December 2021. They were in the process of completing their relevant qualification and it was anticipated that this course would be completed by April 2022. The centre had a stable management team in place following this appointment and it allowed senior managers who had taken temporary roles in management in the centre to resume their role in senior management positions within the organisation. This resulted in a stable and clear internal and external management structure with clear roles and delegation of responsibilities assigned to each position.

From a review of centre records, it was clear that the new acting social care manager was providing good leadership and was available for support and guidance to the team. Clear management meetings were in place to address deficits in the organisation and running of service. Team meetings were in place which included standing agenda items and records of discussion reflected this agenda. A review of paperwork by inspectors found considerable improvements which addressed the deficits noted in the previous inspection report.

Improvements were noted with the recording of staff present in the centre. The inspectors sampled the live and planned rosters and cross examined these against the handover logs and keyworker weekly reports. Although improvements had been made at times the inspectors found that at there was small discrepancies found between the final roster, handover logs and weekly key working reports that staff had signed. Continued improvements are required in this regard.

Oversight and support were provided to the acting social care manager by external management and took place in many different meeting forums combined with onsite visits and supervision.

The inspectors reviewed the acting social care manager's supervision record and found that a comprehensive agenda was in place. There was clear recording of all issues discussed and actions to be completed with timeframes. The records evidenced discussion around the implementation of risk registers in the centre and actions required. The inspectors found the tool to be effective and it included a date of completion of supervision and the date due for next supervision. Supervision minutes were not always signed, and improvement was required in this regard.

Oversight and governance mechanisms were in place externally and internally in the organisation. The presence of external management visiting the centre to provide oversight was clearly visible and had improved significantly. The inspectors found that the CEO, Director of Care, Regional Manager and Quality Assurance manager visited the centre on a regular basis. They completed an overall observation and visual check which was clearly documented and comprehensive. The inspectors found that the visits were planned as part of the external management meeting on a monthly basis.

Although stability within the management structure and governance and oversight had improved the quality of the oversight and governance required improvement.

The internal audit tool was of a good standard with clear oversight of the day to day running of the service. Internal audit identified issues some of which were rectified on the day. While the internal auditing process was comprehensive and regular it requires improvement, as there was no sign off for completion of allocated tasks or a column for management oversight of these audits which in turn may lead to issues around the follow up verification process. The acting social care manager advised that while they had not completed the associated column for verification, they had checked the files to ensure completion and would ensure that the tool would be fully completed going forward.

The person who was responsible for the external auditing of the centre had returned to this position as a Quality Assurance Manager since early January. Previous to this the inspectors found that an audit had been completed by the Directors against theme 1 of National Standards for Children's Residential Centres, 2018 (HIQA) in November 2021.

The Quality Assurance Manager completed a further audit of this theme in March 2022 as part of the discussed plan for auditing of services. Audit themes and schedules were discussed as part of the regional management meetings. Inspectors found that the tool may require some improvement for clarity as comments, completed actions and sign off were all recorded in the same column. The completion and verification of same/oversight needs to be clearer and reviewed shortly after to ensure actions followed through.

The centre had updated the service's Risk Management Policy which included a risk matrix which was aligned to Tusla's Risk Management Framework. The centre held three types of risk registers: an organisational register, centre register and a young person's register. These registers contained open and closed risks with the relevant risk assessments in place. Risk was discussed at external meetings and through case management at staff team meetings. Oversight of risk was provided at many different levels from the centre manager to the Regional Manager and the Senior Quality Assurance Manager. There was an entry for open risks in relation to recruitment and staffing and this remained under review. Ongoing monitoring of risk was noted in relation to open risks; however, the register indicated a small number or risks had not been updated/reviewed. Some risks discussed at management meetings had not been placed on the risk register.

Whilst this was a review specifically of the centre's CAPA, the inspectors expanded their methodology to review the specific management and governance and oversight of one incident in the centre.

A concern was raised by one young person on the 08th February in relation to a senior member of the organisation. This was notified by the acting social care manager on the 09th February to the Quality Assurance Manager. The inspectors found that this concern was categorised as a complaint and verbally notified to social work department. The Quality Assurance Manager completed an internal investigation, and the risk was placed on the organisational risk register with an associated organisational risk assessment put in place.

The inspectors found that the Acting Social Care Manager who was the Deputy Designated Liaison Person for the centre and the Senior Quality Assurance Manager had reviewed this concern and deemed that it did not meet the threshold for completing a child protection concern and welfare report. The centre's Safeguarding Policy at the time of the event stated the following:

Page 5: "To ensure best practice, where a concern arises and we are unsure if it meets reasonable grounds for concern, then in these instances, you need to follow the following procedures":

- *Contact the Social Worker to see does it fit in under 'reasonable grounds for concern' or not and then record what they told you to do/not to do and evidence same in your records.*
- *DLP and DDLP to be notified of the outcome of the discussion in writing.*

The centre had followed their own organisational policy however, the inspectors found that that policy was not in line with Children's First 2017.

The inspectors found that an organisational risk assessment was completed in relation to the above concern. The organisation's Safeguarding Policy Page 5 states the following:

The Children's First Act, 2015 places specific obligations on organisations which provide services to children and young people, including the requirement to:

- *Carry out a risk assessment to identify whether a child or young person could be harmed while receiving your services (please also see Child Safeguarding Statement)*

Section 11(1)(a) of the Children First Act 2015 defines risk as "any potential for harm to a child while availing of the service."

The inspectors found that a risk assessment was completed which identified the concern as a complaint. The inspectors found that the risk assessment completed was not robust enough and did not assess risk to all young people in the organisation as the concern was not categorised correctly. The control measures in place were not robust as the inspectors found that the risk assessment was only applied to this centre and not other centres in the organisation where the senior manager may have been present.

Following this further information was noted on the 02nd March in which the young person and mother made an allegation against the same person. The centre had updated there Safeguarding policy on the 04th March however, the inspectors found that where further information was discovered on the 02 March, they failed to report this concern in line with the organisations Safeguarding Policy, which states the following:

Page 5: "In the instance that the concern does not meet the "threshold for reporting" a CPWRF will still be submitted in this instance under a "child welfare concern"

On this occasion the centre failed again to report this as a CPWRF notification in line with Children's First, 2017 despite the information provided.

The centre convened a multi-disciplinary meeting with all professionals on the 03rd March to discuss same. Following this meeting it was decided among all professionals to process this allegation as a formal complaint and complete a significant event notification of same.

The inspectors acknowledge that although multi-disciplinary meetings had taken place with all relevant parties it does not absolve a mandated person's responsibility within this service to appropriately identify harm or risk of harm to a child and report this concern raised by one young person and their parent in line with Children's First, 2017.

At a meeting on the 21st March it was decided that the senior staff member would resume their normal duties as the young person had been discharged, despite the fact that the investigation into this matter was still ongoing. The inspectors found that based on information received on the 02 March that the corresponding organisational risk assessment and register should have been updated to reflect this most recent serious allegation. Although the centre had implemented some risk management mechanisms the management of risk in relation to one young person was not robust or aligned to best practice.

Overall, the inspectors found that the centre had made significant improvements with regards to the leadership, oversight and governance and had implemented a range of systems to support effective service delivery. However, the strengthened management structure combined with the various mechanisms in place to manage and oversee risks and safety of young people were not effective to ensure the delivery of safe care in the incident noted above. The inspectors were not satisfied that incidents of concern and risk were effectively identified, categorised and managed within the organisation in line with legislation, policy and best practice. The centre failed to report this concern through the Tusla Portal to the Duty Assessment team for independent investigation in line with Children's First, 2017 and this did not allow for a transparent and independent review. Governance and oversight systems

in place did not result in the incident being managed in line with the organisation's own safeguarding policy.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that all employees receive ongoing training in the centre's Risk Management Policy to ensure the ongoing identification, assessment and management of risk is effective.
- The registered provider must ensure that staff and management correctly identify and manage incidents in line with policy.
- The registered provider must ensure that all child protection concerns are reported in line with Children First.
- The registered provider must provide the ACIMS in writing the outcome in relation to the above concern.
- The auditing processes of both the acting social care manager and QA manager required a verification process to ensure all identified actions were followed up and completed.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

The acting social care manager was supported by a deputy manager, three social care leaders and four social care workers. This was not in keeping with the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7: *Staffing*. The centre only had seven social care staff and they utilised 14 additional persons external to the centre to support the covering of shifts. The minimum requirement for registration is eight full-time whole-time staff. The acting social care manager confirmed that the centre required one more post to be filled due to the dismissal of one staff member early February. This new applicant was due to start in April. A relief panel was in place and was shared across all five centres in the organisation to support the staff team when required.

Work force planning for the centre was reviewed at a range of meeting forums which involved discussion on staffing, recruitment, roster planning and retention. Workforce planning remained a standing agenda item at these meetings. Meetings were held monthly, were well attended and took into account the needs of the organisation. Clear discussions and agreed actions were recorded and tracked. The inspectors found that the organisation had engaged in an online recruitment campaign which included canvassing in colleges.

The previous inspection identified an issue with the movement of staff out of the centre and the organisation was required to complete an internal review to address this issue. The inspectors examined this review and found that there were four incidences of staff moving out of the centre to other centres. In all incidents the swap was necessary due to staff safety based on a risk assessments. A follow up review was completed one month later which found no additional swaps occurred and the organisation noted this would only happen where absolutely necessary. On review of the centre's rosters the inspectors found that on two occasions in January that this practice had re-occurred. This was also risk assessed and was based on significant threats from one young person. They found discussion in relation to this at the external management meetings. This young person has since been discharged on the 21st March with the staff member resuming their position in the centre.

The inspectors noted the level of relief staff and staff from other centres utilised over a 4-month period to be considerably high. In discussion with the acting social care manager, they explained that the reason for this was due to the above staff member moving to another centre for safety concerns combined with an outbreak of covid. The acting social care manager stated that it was agreed among the organisation that this roster line would be filled by one staff member per shift from another centre resulting in this increase. On review of a sample of rosters the inspectors evidenced

that 14 other staff members had completed shifts in the centre as a result of the above which may impact on the continuity of care. They also found that back-to-back shifts were utilised on four occasions, at times there was no day cover and the acting social care manager had completed shifts. The director of care must ensure effective organisational workforce planning mechanisms remain in place to ensure that staff deficits are robustly reviewed and do not impact the continuity of care for all young people in the service.

A sample of personnel files reviewed by the inspectors found that each file contained all the necessary documentation. The centre had implemented a handwritten audit that had recently been completed on file however, it was not signed and did not clearly indicate who had completed the audit and would benefit from being typed. There was no sign off from regional management evident, but the inspectors noted that this had only been recently completed.

The service had reviewed the on-call policy as required from the previous inspection report. This policy was satisfactory. The centre operated a regional on call system which was provided by social care leaders, deputy social care manager and social care managers. It operated as a dual two tier system with two people identified; one as a primary on call and the other as a secondary back up on call. The secondary on call provided additional support to the primary on call in managing any difficulties. The centre had implemented formal on call records which clearly detailed the reason for contacting an on call support and the response they received. This record would benefit from the name of the person on call included to be recorded/signed off. The designated-on call person received weekly handovers from each center manager in advance of their cover to ensure support was effective. The acting social care manager confirmed that the on-call manager would send these records to the senior management meeting at the end of each month for review. Oversight and review were evidenced from the regional manager.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The director of care must ensure effective organisational workforce planning mechanisms remain in place to ensure that staff deficits are robustly reviewed and do not impact the continuity of care for all young people in the service.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider must ensure that all employees receive ongoing training in the centre's Risk Management Policy to ensure the ongoing identification, assessment and management of risk is effective.	The risk management policy was reviewed with the internal management team 09.05.22 and it will be reviewed with the staff team at the team meeting 27.05.22 to ensure all staff are aware of the Risk Management Policy. The Regional Manager reviewed all risk assessments during the Regional Manager Centre Monthly Management meeting on 06.05.22 and again during a Centre visit on 11.05.22 to ensure the completion and review of all young person risk assessments. All risk assessments are now in line with the Centre risk register. On 13.04.2022, the Senior Quality Assurance Manager identified a deficit in the new template for risk assessments in regard to effectively recording evaluations and this template was updated and sent to all on	The Centre Management team is responsible for ensuring that policy reviews take place with the team on an ongoing basis via team meetings and via CPD sessions. Where deficits arise, the Centre Management will conduct a learning piece with the team/ team members. Quality assurance themed audits will take place by the Senior Quality Assurance Manager which will include a review of the team's knowledge of the risk management framework procedures in place. The review of risk registers and assessments will remain a standing agenda on the Centre Regional Manager Meetings to ensure deficits are identified early and responded to in a timely manner.

		13.04.2022 and is now in effect. Improvements have been noted since its implementation. In addition, the Senior Quality Assurance Manager will complete a risk assessment evaluation training piece with the Centre Manager and Deputy Manager on 10.06.22 with regard to the assessment and evaluation of risks.	
	The registered provider must ensure that staff and management correctly identify and manage incidents in line with policy.	On 27.05.2022 – a significant event review will be completed regarding the incident compared to Centre policy. This review will occur with the Centre Team and Senior Management Team in attendance to promote learning regarding how the incident was managed and to identify the deficits with the management of this incident to promote learning. This report will be shared with inspectors upon completion.	Senior Quality Assurance Manager will receive formal training in the role of DLO by 31.05.22 to ensure that effective cover in in place when the Regional Manager who is the DLO is on leave.
	The registered provider must ensure that all child protection concerns are reported in line with Children First.	The incident was reported as a child protection concern in line with children first on 21.04.2022 and has since been	Two members of the senior management team will have training as DLO's to ensure this issue does not arise again. In addition,

		unfounded. The Regional Manager provided training at the team meeting on 29.04.22 in relation to reporting child protection concerns in line with Children's First. The identified significant event review scheduled for 27.05.2022 will further strengthen the learning required.	Centre Management will be responsible for ensuring the ongoing review and evaluation of child safeguarding policies in house. The Regional Manager will continue oversight on all weekly reports and incident reports to ensure any deficits are responded to in a timely manner. The DLP with oversight from the DLO are responsible for ensuring that all possible child protection concerns are reported via the Tusla Portal in line with Children First
	The registered provider must provide the ACIMS in writing the outcome in relation to the above concern.	The senior quality assurance manager provided the ACIMS the outcome in relation to the above concern 13.05.22	Not applicable
	The auditing processes of both the acting Social Care Manager and QA manager required a verification process to ensure all identified actions were followed up and completed.	The QA auditing tools were updated on the 09.05.22 to include a section for the outcome of the audit to allow for verification that the actions identified were completed within the assigned timeframe.	The updated auditing tools are to be used to ensure this issue does not arise again. The Director of Social Care / Regional Manager/ Senior Quality Assurance Management and centre management team are responsible for ensuring this.
6	The Director of Social Care must ensure effective organisational workforce	The staffing deficits have been rectified and the inspectors have been updated.	The registered proprietor will ensure at least four recruitment drives per annum to

	planning mechanisms remain in place to ensure that staff deficits are robustly reviewed and do not impact the continuity of care for all young people in the service.		ensure effective workforce planning.