Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 050

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Home Again**
Registered Capacity:	**Five young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**15th & 17th of September 2021**
Registration Status:	**Registered from the 28th of February 2020 to the 28th of February 2023**
Inspection Team:	**Eileen Woods** **Lisa Tobin**
Date Report Issued:	**20th December 2021**

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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 28th of February 2002. At the time of this inspection the centre was in its seventh registration and was in year two of the cycle. The centre was registered without attached conditions from the 28th of February 2020 to the 28th of February 2023.

The centre was registered to provide care for up to five young males, aged between thirteen to seventeen upon admission. The placements were on a medium to long term basis. There were four young people living at the centre at the time of the inspection. In exceptional cases the centre takes children outside of this age group under derogation through a process with the alternative care inspection and monitoring service, ACIMS, Tusla. In line with this process, one child under thirteen years was residing in the centre. The centre's model of care was described as based upon a therapeutic and relational child centred approach identifying individual needs and responding to them in a safe and secure environment.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
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 on the 22nd of October 2021 and to the relevant social work departments on the 22nd of October 2021. 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 4th of November 2021. This was not deemed to be satisfactory and on the 9th of November 2021 the inspection service a more detailed response with evidence of the issues addressed. The centre manager and director of service returned an updated response inclusive of evidence of actions being addressed on the 24th of November 2021 which was found to meet the threshold for corrective and preventative actions and to bring the centre into compliance with the relevant regulations.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 050 without attached conditions from the 28th of February 2020 to the 28th of February 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

Inspectors were presented with well organised files for review for the four young people living at the centre. One of the young people aged under thirteen did not have a care plan completed within a month of admission in line with the National Policy in relation to the Placement of Children aged 12 years and under in the care or custody of the Health Service Executive. The care plan meeting was booked to be held six weeks after admission. Another young person was nearing eighteen and there was an aftercare worker assigned by their social work department but no copy of the aftercare plan and needs assessment yet provided to the centre. There was evidence of requests made to the social work department for a child in care review six months before the young person's eighteenth birthday. The centre utilised a process of escalation to their organisations director level where no progress had been made with requests for necessary planning, including statutory care planning, meetings and provision of documents such as care plans for young people.

The two other young people had child in care reviews held in accordance with the statutory time frames and had some but not all copies of care plans on file in accordance with the numbers of meetings held. The social workers explained that these documents were being released post the Tusla cyber-attack and following additional local access issues that were being resolved. The young people had records of current agreed actions on file and of the ongoing outcomes to any special reviews, family welfare conferences and complex case processes. The centre maintained minutes of all child in care reviews attended and of all other planning and response meetings convened. The centre also maintained records of emails and calls with social workers and the social work departments.

There were up to date placement plans on file for all of the young people and the structure and time frames for placement planning was supported by a policy and procedure document for staff. The placement plan policy operated on a six month time frame for the overarching plan with monthly centre case management reviews creating a monthly plan for each young person. The case management meetings

involved the two key workers, a social care leader and the young person themselves in setting and agreeing key areas to address. These meetings and feedback to the inspectors from two of the young people showed that the young people did sit down with their key workers and talked about their plans in a way tailored to gain their involvement. Areas of disagreement, for example about boundaries and expectations, were dealt with openly and the goal at all times was to engage the young person. Overall, the two young people who spoke to inspectors agreed that their key workers knew them and helped them as well as challenged them at times. They didn't always agree but they knew why the staff were attempting to support them in the way they were. The focus was typically providing stable daily routines in education, well-being, safety, health and stability.

Inspectors found that the placement plan format was well structured with actions and needs identified with a focus on holding hope for the future in key areas of challenge for some of the young people. Monthly reports were completed by the key workers and the social workers stated that they received regular key work reports, updates and had visited the centre. The key working records contained scheduled key work and individual work. Some areas identified on the placement plan for action were not recorded on file despite being noted as having commenced, it is important that staff keep up to date records of the work they have undertaken. Inspectors also found that where there had been clinical or external professionals' advice whether sourced by the centre themselves or from external professionals that the staff should focus on reflecting that more clearly on file. The team displayed their awareness of and ongoing guidance in trauma informed care and should focus on how they reflect this more in their planning and records.

The centre had three group processes available to the young people that they utilised well, one was a young peoples' meeting, another a reflection type group and a third provided a therapeutic art outlet.

The young people had a range of external professionals involved and there was ongoing assessment occurring at the time of the inspection about new supports that may be required. The team were experienced and adept at communicating and collaborating with a range of other voluntary bodies, Guardians ad litem, assessment consultation therapy service/ACTS, education and welfare officers and other youth support groups and clinicians.

The young people and their families, where possible and accessible, were involved in meetings, plans and access arrangements. There was evidence of staff connecting

with families and of staff supporting access in accordance with all agreed access plans. Families had been invited to the centre and it was possible for young people to contact and visit family outside of Ireland.

Compliance with regulations	
Regulation met	**See Standard 5.2**
Regulation not met	**See Standard 5.2**

Compliance with standards	
Practices met the required standard	**Standard 2.2**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Action Required:

- None

Regulation 5: Care Practice s 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 centre was being run by an appropriately qualified and experienced acting social care manager at the time of this inspection, they had taken up the post to cover a period of specified leave for the full-time manager. They had records on file of their delegated duties and those of the centre's social care leaders and social care workers. They had prepared for the role alongside the outgoing manager and was an experienced member of the long-term team.

The acting social care manager was the person in charge of the centre for the period of leave. They undertook their role through planning and preparation, informed by

review of centre documents, attendance at handovers, team meetings and at key meetings related to young people's placements. The staff team were clear about the social care management arrangements and about the organisational structure of the voluntary body. The social care manager was well organised and structured in their approach to the work. They were supported in their role by the two full time and one half time social care leaders and by the director. There were internal monthly audits completed and the director completed some additional auditing, typically desk top informed during the pandemic. Inspectors found that file external audits did not adequately identify areas for improvement in, for example personnel files or behaviour management, due to how they were presently constructed. These must be reviewed to ensure that they fully support a learning environment through more qualitative analysis.

The voluntary body had agreed their service level agreement with Tusla and continued to advocate for increased funding in future agreements. The director and the social care manager meet for monthly senior management meetings and for supervision. The senior management meeting aimed to look at outcomes and inspectors recommend that they include formalised risk review and group mix discussion more clearly. The social care manager also held internal senior team meetings and these informed the staff team meetings, both were recorded and held fortnightly.

The director of service alongside the two social care managers from within the organisation had created a range of policies and procedures in 2021, a number of these related to risk management and taken together represent the organisation's and the centre's approach to a risk management framework. Inspectors recommend that these be co-ordinated or cross referenced more clearly as a combined framework. Items related to health and safety risk management were clearly defined in particular and easy to track, whether it pertained to health and safety audits, a health and safety representative, safe management of medication and related areas. The centre had relaxed their pandemic related control measures in line with public health changes and these changes had been approved by the director.

The inspectors found that it was in the areas of risk related to behaviours that challenged that required further attention. The centre was in the middle of a period of challenging high-risk behaviours, a number of incidents had taken place not all of which were recorded as sufficiently examined to inform changes in the management of behaviour at the centre. The Gardaí had been called to address young people's unsafe behaviours and the team were unclear about what constituted suitable levels

of staffing at times of crisis. When young people had left the centre without staff knowledge and this had been reviewed through a risk assessment process and practical changes made following this to improve the security at the property.

Group and individual risk assessments were in place and discussed at team meetings at key times but the minutes did not reflect what the process in response to changing risk was. The policy in place did not account for the escalation process that was in place and the centre were not utilising the risk management plan fully as an integrated tool. There was no measurement of risk as such and therefore tracking of impact of interventions was difficult to see in practice. There had been several periods of impact inclusive of complaints of bullying several times in the year and incidents of escalating risk within the centre. These highlighted the necessity for a risk management process that clearly evidenced and tracked identification, assessment, management and review in order to comply with their own policy.

There was a structured historical format for combined placement support, PSP's, which incorporated behaviour and crisis management planning. Within the centre it was not fully clear how the team were responding to new or heightened changes in behaviours that decreased safety within the centre as the PSP's did not capture this fully. It was unclear what the shared understanding was of what risk the team could hold, respond to and what needed to be escalated externally. Inspectors found that the director must review the risk management system where it connects to crisis management at the centre, that there must be a means of tracking such as a register that benefits tracking, response/controls, outcomes and learning and that it supports the team in recognising, defining and responding to varying levels of challenge.

Compliance with regulations	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5**

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 director must ensure that the auditing process adapts to reflect quantitative findings in order to further enhance the culture of learning, quality and safety at the centre.
- The senior management team must ensure that all meetings and records reflect their review of risk management and response where required.
- The director must review the risk management system where it connects to crisis management at the centre in order to further define appropriate levels of response to serious incidents.
- The director and the centre manager must ensure that the risk management framework can support tracking and identify responses or control measures in place. This process must include outcomes and learning for the team in recognising, defining and responding to varying levels of challenge.

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 director of services and the social care manager completed monthly work force planning meetings and this was a relatively new format that they had introduced as part of their governance, oversight and planning framework.

The social care team was made up of a social care manager plus ten posts shared between twelve people. There were two and a half social care leaders and seven and a half social care worker posts active. There were also three relief staff available to the centre. Of the thirteen core staff inclusive of the manager ten had a social care qualification, two had related and relevant qualifications and another was not qualified in a related field but was a long term experienced staff. The social care manager maintained well organised and detailed rosters that clearly recorded all sick leave, annual leave, parental and study leave as well as toil accumulated. There was evidence of significant demands on roster changes and need to utilise relief staff and other staff to provide double cover recently, the manager had co-ordinated this well and maintained good records of who was working at the centre. There was provision for day shifts on the roster but these were most frequently utilised for leave

requirements. Of a sample of days counted during August into September there was a day shift on for approximately eleven out of twenty nine days. For some of this period a young person was on extended family holiday and the fourth young person was still transitioning into the centre. The director of services stated that double cover was the standard provision and adequate to meet the needs of the young people. The key discrepancy that inspectors found was that there was not a shared understanding of what a safe level of staff was when in crisis or on foot of agreements for certain admissions, for example where high supervision was named. It is important that in a property of this size, with a variety of ages and stages of development of young people and taking account of significant events analysis that clear risk assessment informs staffing levels and that actions to address that are tracked.

Inspectors found that the core team at this centre were long established, experienced and qualified. They had a range of skills and abilities as well as knowledge acquired in order to fully support young people to meet their potential. One young person told inspectors that there was a great opportunity at the centre to do well if they themselves were willing to accept that help. Inspectors could see on the plans and discussions that the team were skilled at providing young people with those opportunities. The team worked in a trauma and attachment informed approach with the support of a clinical advisor and this was evident in the hope they held for the young people and support they offered them.

Inspectors reviewed a sample of three personnel files and found that they required action to address the provision of clear CV's on file to facilitate tracking of references, gaps in employment and last employer. References that were on file did not all have evidence attached of the source of the reference and the verbal verification process was noted in a cursory manner. A newly recruited staff member must provide the relevant up to date clearance for overseas locations in line with the dates of residing in those countries, where time frames in that country allow for same. There was also pending verification of qualification required for a personnel file.

The organisation had an updated employee handbook and sought to support training and development as one means of staff retention. There was a stable long term team at the centre and the director ensured that the team had free access to a specialist clinical support therapist on an individual and confidential basis following any incident where they require individual debriefing or specific interpersonal support. The director added that they hoped to further enhance staff support packages in 2022

and that staff supervision and ongoing support from the centre management was in place also.

With regard to training the social care manager was tracking completion of key training delayed by the pandemic for example training in the method of managing crisis behaviours, use of ligature cutters and first aid.

There was an on call service for evenings and weekends provided in addition to the social care managers and director role, there were no formalised records maintained but the use of on call was recorded on significant events reports and the advice noted. The director stated that they and the board were satisfied that the arrangements represented a safe standard of governance for weekends and evenings.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The director and the centre manager must ensure that admissions agreements, derogations and clear risk assessment informs staffing levels and that where additional staffing levels are required to meet the assessed needs of the young people that this is tracked for impact and service development needs.
- The director and centre manager must complete the required updates to the identified personnel files and update their auditing mechanisms accordingly.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	None identified		
5	The director must ensure that the auditing process adapts to reflect qualitative findings in order to further enhance the culture of learning, quality and safety at the centre.	Senior management are in the process of refining and structuring a qualitative thematic audit that will reflect the areas for learning, quality and safety. At the time of inspection, the Director utilised the monthly manager report which is aligned with the Standards to focus on specific aspects of service provision. As part of this governance from the last quarter of 2021 we will be implementing the wider Director review as part of our global risk review of the year. Commencing in January 2022, there will be a qualitative audit consistent with the themes conducted every two months with two Standards focused on. This approach will allow for oversight and ongoing governance evaluation while also	The more structured audit will complement the existing monthly manager audit and will be utilised on a bi-monthly basis.

		supporting the team to work toward being prepared for more consistent auditing. The Director will utilise the Manager's reports, SEN Review minutes, Risk Review monitoring and management tool to inform the audit alongside a deeper dive analysis of key outputs.	
	The senior management team must ensure that all meetings and records reflect their review of risk management and response where required.	A risk management working group involving the Centre Manager and Social Care Leader is established with the objective of integrating a whole of organisation approach to recognising, measuring and monitoring emerging risks. The working group commenced in November with a refined risk monitoring tool developed by the Director in consultation with the Centre Managers. This is an ongoing core operational group that is focused on identifying, monitoring and managing emergent risks allowing for relevant escalation processes to be identified at the appropriate stages.	The working group will determine a structure for more systematic measurements of ongoing risks.

	The director must review the risk management system where it connects to crisis management at the centre in order to further define appropriate levels of response to serious incidents.	A fortnightly risk review group is established, chaired by the Director and attended by a Centre Manager and Social Care Leader to review ongoing and emerging risks. All live risks will be reviewed with an overview of interventions and preventative measures evaluated for effectiveness. Recommendations regarding appropriate escalation processes will be offered in situations where risks are persisting and/or we determine an unreasonable impact or risk of harm and or injury to the young person in question or another young person in the care of Home Again	The purpose and function of the risk review group is to identify, measure and monitor emerging risks with recommendations for intervention or escalation provided by the review group to the manager with a fortnightly review process.
	The director and the centre manager must ensure that the risk management framework can support tracking and identify responses or control measures in place. This process must include outcomes and learning for the team in	The established risk review group will track, monitor and recommend control and or safety measures. The recommendations emerging from the group will be communicated via the daily handover in terms of immediate updates required for risk assessments or placement	The review group will consider patterns of challenging behaviour, associated staffing levels, appropriate control measures in the house and where appropriate recommend relevant escalation actions.

	recognising, defining and responding to varying levels of challenge.	planning, the recommendations will also form part of the team meeting and house management meeting fixed agenda.	
6	The director and the centre manager must ensure that admissions agreements, derogations and clear risk assessment informs staffing levels and that where additional staffing levels are required to meet the assessed needs of the young people that this is tracked for impact and service development needs.	The organisation always considers the needs of the young people in relation to the level of staffing in the house. At times, there can be staff be shortages, however, the organisation makes all reasonable efforts to mitigate these shortages and always ensure a minimum number of staff consistent with funding arrangements and minimum staffing levels recommended by the inspectorate. The minimum number of staff we are funded to have on shift is 2 and the organisation strive to ensure adjustments to this minimum number in situations where we identify increased likelihood of risks. The organisation is currently reviewing all aspects of workforce planning, with consultations occurring with staff and new rosters being implemented for 2022, this will include a more structured approach to managing	At the time of inspection, the organisation had engaged all staff in an organisation wide workforce planning review, part of this review considers the existing approach to rosters and will involve adjustments consistent with the findings of the inspection.

	The director and centre manager must complete the required updates to the identified personnel files and update their auditing mechanisms accordingly.	day shifts in line with the needs of the young people. The Centre Manager has requested the relevant information for the personnel files.	Both Centre Manager and Director conduct personnel file reviews at a minimum twice per year.