An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 114

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Terra Glen Residential Care Services Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**19th & 20th October 2021**
Registration Status:	**Registered from 14th March 2019 to 14th March 2022**
Inspection Team:	**Catherine Hanly** **Cora Kelly**
Date Report Issued:	**22nd 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 14th of March 2016. At the time of this inspection the centre was in their second registration and was in year three of the cycle. The centre was registered with an attached condition from 14th of March 2019 to the 14th of March 2022.

The centre was registered to accommodate two young people of both genders from age thirteen to seventeen on admission. Their model of care was described as a pro-social modelling approach implemented by staff through a relationship based and attachment theory informed framework. There were two young people living in the centre at the time of the inspection, one of whom was due to move in a planned way to their aftercare arrangement in the weeks following the onsite inspection.

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. This was a blended inspection carried out onsite through a review of documentation and a centre management interview. Telephone interviews with staff and social workers were conducted remotely.

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 29th of November 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 13th of December 2021. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

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: 114 without attached conditions from the from 14th March 2019 to 14th March 2022 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.

There were two young people residing in the centre at the time of the inspection, both of whom had up-to-date statutory care plans on file. Inspectors noted that the level and specificity of information contained within these documents varied. For example, one did not document who participated or attended in the care planning meeting and lacked details around identified actions. The other plan, whilst heavily detailed in content, also lacked detail around actions with no designation of persons responsible for realising actions. Despite these deficits in the statutory care plan documents on file, centre management were confident that individual responsibilities for the realisation of aspects of care provision were clearly agreed, understood, and regularly reviewed by centre management with the respective social workers. There was evidence on files at the centre to support this through ongoing telephone and email contact as well as regular meetings as required.

Both young people had up-to-date placement plans on file. These plans covered a three-month period and were reviewed and updated at monthly placement plan meetings which were attended by centre management and key-working teams allocated to both young people. Progress reports were completed at the end of each three-month period and were shared with the allocated social workers. The structure of the placement plans allowed for goal setting across five identified areas; detail regarding the centre's implementation strategies; staff assigned to identified tasks; timeframes; and outcomes. Inspectors found that the system in place was clearly understood by the staff and management team and was realised in practice as the structure set it out. Inspectors found from their review of a sample of the various documents that related to placement planning that the goals, whilst being connected to the statutory care plans and considerate of the young people's views/wishes, were not always tracked through that system from initial quarterly plan development, through monthly reviews, monthly plans and meetings. Staff interviewed concurred with this finding and had noted it themselves. This was particularly evident where changes occurred in response to presenting needs of young people and these then took precedence within the placement planning, and in particular the monthly plans

for the young people. However, whilst this is often relevant, the young person's identified needs and goals identified to meet these should also be consistently tracked. Inspectors noted that the placement planning documents lacked evidence of clinical input despite internal and external clinical support having been sought and provided to centre management for both young people. This finding reflected a similar one identified by the Alternative Care Inspection and Monitoring Service (ACIMS) during an inspection of another centre operated by the company earlier in 2021. There was also a lack of integration of learning from specialist training completed by the team specific to the needs of the young people in this centre. Inspectors recommend that the centre manager review the placement planning process to ensure that the structure is maintained whilst keeping a focus on individual placement goals as identified in statutory care plan meetings and being appropriately responsive to need. The input and support sought to achieve goals via training and clinical expertise must be reflected within placement planning documents so that progress and outcomes can be consistently tracked.

There were opportunities for young people to contribute to both their care and placement planning goals which was age appropriate. However, as noted earlier, statutory care plans did not always note their contribution and participation. Both young people had participated in their respective aftercare planning processes. The content of this plan for one young person, required significant additional detail. Inspectors noted that there was no apparent connection between aftercare plans for young people and their individual placement plans and improvement in this area is required to ensure that these plans are complementary and inclusive of one another.

Both the young people resident at the time of this inspection had been provided with access to specialist services throughout the course of their respective placements in response to presenting or identified need. There had been varying degrees of uptake/engagement with these services by the individual young people though attendance and engagement had been encouraged and supported well by the centre. There was evidence across records reviewed to indicate that the centre had constantly endeavoured to source services to meet the needs of the young people. Additionally, there was evidence that the manager had sought specific training for the team as a response to presenting needs. As highlighted earlier, the inclusion of direction/input from specialists must be included in placement plans.

Inspectors found evidence of good communication between centre management and both social work teams. This consisted of open communication which enabled social workers to be regularly appropriately informed of all aspects of the placement

progress. In addition, strategy meetings were convened with more senior members of the social work team, and other professionals where relevant, in response to crisis situations that had occurred within placements at various junctures. These latter meetings ensured clarity of respective roles and responsibilities so that placements could be supported and maintained. Inspectors only secured an interview with one allocated social worker, and they were extremely positive and complimentary of the work of the centre and their engagement with them.

Compliance with Regulation	
Regulation met	**Regulation 5**
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 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that the input and support sought to achieve goals via training and clinical expertise is reflected within placement planning documents so that progress and outcomes can be consistently tracked.

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.

Inspectors found that the internal management structure, consisting of manager, deputy manager and three social care leaders, was appropriate to the size and purpose and function of the centre. There was a clearly demonstrated understanding

of respective roles and inspectors found that regular internal management meetings ensured this as well as ensuring accountability for delivery of assigned tasks in accordance with job descriptions. The deputy manager was the appointed person that had responsibility for taking over the duties of the manager in their absence and inspectors were provided with records of delegated duties which were maintained. Inspectors recommend that more explicit information is detailed within these records, particularly where it relates to the duties of the deputy manager when covering periods of absence by the manager.

The centre manager was the designated person in charge with overall executive accountability, responsibility and authority for the delivery of the service. They had been in post for a period of four years and during that time had provided consistent leadership, guidance, support and direction to the staff team. This was evidenced during interviews as part of this inspection process, and through a review of staff meeting records, and across care records reviewed. The manager had created and continued to facilitate a learning culture for the management and staff team.

The manager reported to the director of operations formally on a regular basis as well as being in frequent telephone contact. The director of operations supported the manager in their role through formal supervision and by attendance at placement planning meetings as required. The governance structures in place were evidenced in team meetings, management meetings, senior management meetings, audits and in the significant event review group (SERG) meetings. Based on their review of a sample of records provided, inspectors recommend that this latter forum be improved, again a matter that had previously been identified by the ACIMS during another centre operated by this company. Inspectors did note that changes had been made to the structure and accompanying template of this meeting, but further improvement is required to optimise the feedback, learning and actions identified for staff, as inspectors found that the records did not evidence that the meetings were consistently structured. Ongoing attention to and oversight of this mechanism is required to ensure that it is fully fit for purpose. Inspectors also noted that team meeting records showed some gaps in terms of what they were informed consistently occurred in this forum, namely feedback from the centre's clinical specialist and feedback from the SERG. The centre manager will need to ensure greater oversight of the team meeting forum and recordings also.

The centre had a service level agreement (SLA) with the funding body Tusla and at the time of this inspection there was a tendering process on-going by Tusla. As part

of this SLA, six monthly reports were submitted to Tusla that provided compliance with relevant legislation and the relevant national standards.

Operational policies and procedures were reviewed annually and updated/amended as required and in response to feedback from inspections across the services. Training in these was delivered to the management and staff team on a regular basis by the director of operations.

Inspectors were informed that the centre had a risk framework in place. This was evidenced in recorded risk assessments in place; the use of the identified matrix to support the identification and assessment of risk; review of risks and actions/interventions outlined. There was evidence that risks had been escalated appropriately and in a timely manner internally to senior management and externally to the relevant social work teams. Inspectors found that centre management and staff understood the risk framework well. The allocated social worker interviewed by the inspectors expressed the view that it was an area of strength for the centre management and staff team. Inspectors were of the view that the way risks, and associated interventions/management techniques were documented and presented for staff to understand and be realised in practice could be simplified. This was linked to the presenting risks connected with one young person at the time of this inspection. Inspectors found that centre policy, and the layout of the care files, allowed for the use of a safety plan to guide staff in their interactions with and delivery of care for a young person. There were no safety plans in use at the time of this inspection and inspectors were of the view that one should be devised and implemented, in consultation with other relevant professionals including the Gardaí and the allocated social worker. An overarching document that points to the salient information may be more appropriate and helpful to the staff working with this young person during periods of crisis. Inspectors found that the matrix utilised to inform risk assessment may need to be expanded, so it supports the identification of real/immediate risk versus more long term but less risky impact. This distinction had proven to be a challenge for the staff team on occasion and may assist them in responding appropriately to the various risks presenting.

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

- Centre management must ensure greater oversight of review and meeting mechanisms and in doing so, safeguard their intended purpose.
- Centre management to ensure that individualised safety plans are implemented as required. This includes the implementation of a safety plan for one resident currently.

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.

Inspectors were provided with information on the current staff team and staff members that had left this centre since the time of its last inspection by the ACIMS approximately eighteen months prior to this time. It was noted that a total of nine staff, including a deputy manager and two social care leaders, had left their positions at this centre in that timeframe. Reasons for leaving cited included study pursuit and career progression. Exit interviews were conducted by the director of operations however not all staff leaving participated in this process. The centre manager had been in post for four years and had provided consistency to the staff team as well as continuity of care for the young people in placement. They had responsibility for oversight of the staff rota, which was completed by the deputy manager, and within this needed to account for various types of leave. Workforce planning, particularly in the context of ongoing recruitment drives, was a regular discussion topic at senior management meetings. However, at the time of this inspection it was confirmed that the centre had a total of six social care staff plus a deputy manager employed and thus were deemed to not have the appropriate numbers of staffing required regarding

the identified needs of the young people and taking cognisance of the centre's statement of purpose. This fact had been established prior to this inspection by management of the Alternative Care Inspection and Monitoring Service (ACIMS) and had been raised by them with the Tusla Registration Committee. A decision had been taken by that committee and informed to the centre's registered proprietor of the attachment of a condition on the centre's registration. Centre management had identified several staff that had been successful at interview and were onboarding to employment at the centre upon completion of the recruitment process. The understaffing situation had impacted somewhat on the development of the rota and a complete staff team will enable a much greater projection of working schedule for all staff members. The manager informed inspectors that where possible, gaps in the staff rota were filled by regular relief or fulltime staff from one identified other centre within the company. Records reviewed by inspectors confirmed this although it was noted by inspectors that there were occasions where non-familiar/regular staff were utilised to fill gaps. The registered provider will need to ensure that the appropriate numbers of staff are secured and maintained over time at this centre.

Inspectors noted that there was a mix of experience across the staff team with at least two members of staff having less than one years' experience working in a children's residential centre. All the staff team had a social care or relevant equivalent qualification. There was a conscious effort to have the experienced social care leaders on shift with less experienced staff members however this was not consistently done and had resulted on several occasions whereby new recruits had worked some of their first shifts alongside relief staff members. Workforce planning, through the development and implementation of the rota will need to be overseen more stringently to ensure that there is consistently at least one experienced member of staff on each shift.

Centre management described some of the arrangements in place that were aimed at promoting staff retention and continuity of care. These included 'employee of the month', and 'refer a friend' schemes as well as contributions towards health and car insurance and education bursaries. Inspectors noted that in interview staff members did not independently reference these incentives. Based on the turnover of staff across the company and difficulties experienced in maintaining staff, inspectors recommend that management review the arrangements that are currently in place to retain staff and endeavour to be more competitive with their employment packages whish may contribute to continuity of care for young people in this centre.

There were formalised on-call arrangements in place, with persons identified on a rota basis. Inspectors found that there was a lack of clarity demonstrated by staff interviewed regarding what circumstances warranted contacting on-call and therefore recommend that centre managements refresh this with the staff team.

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	**6.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the centre always has the appropriate numbers of staffing required to meet the needs of the young people and the centre's statement of purpose.
- The centre manager must ensure that there is always at least one experienced staff member on duty.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that the input and support sought to achieve goals via training and clinical expertise is reflected within placement planning documents so that progress and outcomes can be consistently tracked.	- SCM has addressed the importance of reflecting clinical recommendations i.e., identified clinicians and CAMH's, within the placement planning documents for progress to be tracked and measured at: - Management meeting on 29.10.21 - Team meetings on 5.11.21 and 19.11.21. - SCM has highlighted this to both keyworkers in case management meetings also. - SCM has addressed this in daily handover. - SCM has addressed this in individual supervisions. SCM has reviewed all documentation in with regards placement planning to reflect the clinical expertise since inspection in	- SCM to oversee that this recommendation is completed by overseeing the following: - Care plan - Quarterly Plan - Aftercare plan - Individual monthly plan - Recommendation of clinical consultant. - Aftercare needs assessment and ensure that all plans are integrated into the Individual monthly plan outlining the key recommendations from relevant professionals. - Progress to be measured: - Daily at handovers - Fortnightly at management and team meetings - Case management meetings. - Formal Supervision.

		October 2021.	- All documents in key working folder i.e., level of key working complete, and the quality of the key working completed will indicate the measure of the outcome.
5	Centre management must ensure greater oversight of review and meeting mechanisms and in doing so, safeguard their intended purpose.	SCM has addressed the importance of recording information from both SERG meetings and clinical specialist via the forum of: - Management meeting held on 29.10.21. - Team meetings on 5.11.21 and 19.11.21. - SCM has addressed this in individual supervision. - SCM has delegated a social care leader to oversee that the team meeting reflects accurately the recommendations from both SERG and Clinical Specialist to ensure continuity of care for the young people in the centre. - SCM will also oversee this documentation to ensure the information is recorded accurately	- SCM has delegated a SCL to oversee the recording of team meeting minutes and SERG minutes. - The role of SCL is to ensure that all sections are completed with accurate information recorded to ensure consistency in practice when working with the young people. - In the absence of the manager at team meetings DSCM to provide the feedback to the team and delegate any tasks outstanding or recommended from SERG or clinical specialists. - SCM to oversee the recording of same and ensure its accuracies. - SCM to ensure that team meeting minutes and SERG minutes are emailed to SCM once completed for her to review.

		as discussed.	- Once reviewed document to be printed and filed.
	Centre management to ensure that individualised safety plans are implemented as required. This includes the implementation of a safety plan for one resident currently.	Following inspection SCM implemented an individualised safety plan for one resident in the centre. SCM reviewed all BSMP's and RAs for the young person and incorporated this into a safety plan. This safety plan was presented to the team on 19.11.21. The purpose of this safety plan was explained to the team and what to do in the event the young persons' safety was at risk. This safety plan was read and signed by all staff. Should the needs of the young person change or the measures to reduce harm to the young person need to change this is reflected in the safety plan. SCM and all SCW's reviewed and updated the safety plan at the team meeting on 3.12.21.	SCM to ensure that safety plan is reviewed and evaluated in accordance with the child's needs. All SCW's are to ensure that they are aware of the documentation and all SCW's are aware of the measures to ensure the young persons remains safe. This document is to be reviewed in consultation with the team on a fortnightly basis.

6	The registered provider must ensure that the centre always has the appropriate numbers of staffing required to meet the needs of the young people and the centre's statement of purpose.	Senior management is actively recruiting for the centre to ensure Manager has appropriate numbers of staff to meet the needs of the young people in the centre. At time of inspection Manager was pending vetting for two full time Staff to commence in their role and they have since completed their induction and have commenced employment. The organisation has incentives in place, that are reasonably practicable, regarding employment retention and plan to do another survey with staff by the end of January to review current strategies.	Senior management complete an employee survey by end of January 2022 and will continue to monitor trends and factors in relation to staff retention. Senior management to implement staff retention as part of the agenda at management meetings and consult with managers as to what reasonably practicable measures could be implemented to improve on employee packages to retain staff.
	The centre manager must ensure that there is always at least one experienced staff member on duty.	SCM completes the rota and ensures that there is always at least one experienced staff member on duty.	SCM to ensure that when completing the rota that there is at least one experienced member of staff on duty.