An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 135

Year: 2018

Alternative Care Inspection and Monitoring Service
Tusla - Child and Family Agency
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Registration and Inspection Report

Inspection Year:	**2018**
Name of Organisation:	**Harmony Care Ltd**
Registered Capacity:	**Four young people**
Dates of Inspection:	**3rd and 4th December 2018**
Registration Status:	**20th of February 2018 to 20th of February 2021**
Inspection Team:	**Eileen Woods Catherine Hanly**
Date Report Issued:	**19th March 2019**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration on the 20th of February 2018. At the time of this inspection the centre were in their first registration and were in year one of the cycle. The centre was registered without attached conditions from 20th February 2018 to the 20th of February 2021.

The centre's purpose and function was to accommodate four young people aged 16 to 17 upon admission in a semi independent, individual apartment setting. Their model of care was described as utilising a trauma informed, positive behaviour support model to promote the further development of life skills. The underpinning model of care principles being the application of a cognitive behaviour therapeutic approach in a trauma informed context. In line with the revised inspection process for new centres an inspection was completed at three months (May 2018) and at that time the capacity was limited by the providers to three placements due to ongoing works. At the time of this inspection these works were nearing completion. There were three young people living there at the time of this inspection visit in December 2018.

This was a nine month announced inspection based on the revised inspection processes and took place on the 3rd of December 2018. The inspectors examined standard 1 'purpose and function' and aspects of standards 5, suitable admissions, standard 6 'care of young people', and standard 7 'safeguarding and child protection' of the National Standards for Children's Residential Centres (2001) were also

reviewed during this inspection. Suitable governance of all these areas of work was considered as a follow up to the recent three month inspection.

1.2 Methodology

This report is based on a range of inspection techniques including:

- An examination of related documentation submitted by the Manager.

- An examination of the questionnaires completed by the social workers for the young people. Three were issued; one social worker returned the questionnaire.

- An examination of the centre's files and recording process
  - care files
  - supervision records
  - registers of complaints
  - register of child protection and welfare reporting forms
  - register of risk assessments
  - register of young people
  - significant review group record
  - three personnel files
  - management folder – internal and external management meetings
  - team meeting minutes
  - policy and procedures
  - application for registration

- Interviews with relevant persons that were deemed by the inspection team as to having a bona fide interest in the operation of the centre including but not exclusively

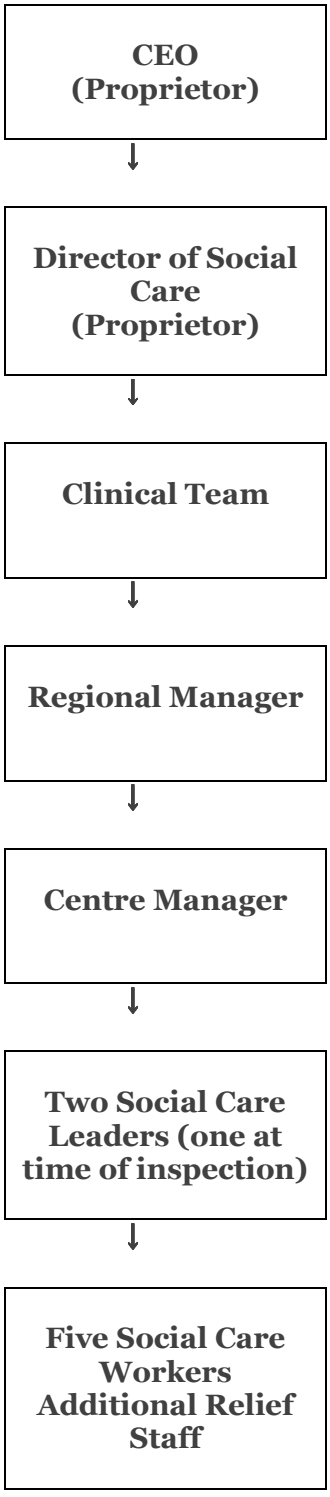
  a) The centre manager
  b) The director of social care
  c) Two young people - informally
  d) The lead inspector

- Some observations of care practice routines and the staff/young person's interactions.

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.

1.3 Organisational Structure



2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, director of social care and the relevant social work departments on the 30th of January 2019. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 5th of February 2019 and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the regulatory frameworks and Standards in line with its registration. As such it is the decision of the Child and Family Agency to continue to register this centre, ID Number: 135 without attached conditions from the 20th of February 2018 to the 20th of February 2021 pursuant to Part VIII, 1991 Child Care Act.

3. Analysis of Findings

3.1 Purpose and Function

Standard

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

3.1.1 Practices that met the required standard in full

The purpose and function of this centre was the provision of semi independent living and preparing young people for leaving care. The centre had four apartments, three were available for use whilst ongoing works were taking place. Since opening in February of 2018 the centre had four admissions and one temporary move from a sister centre within the company for a specific and agreed reason. There had been one discharge and the maximum number of young people living at the centre had remained at three, all were males aged over sixteen upon admission in accordance with the agreed age range.

The team worked with the young people daily to establish routines, life skills and to build on existing strengths and emotional resilience. The team linked in with appropriate local services to further support the young people's development and address their additional needs. The team had appointed a dedicated aftercare staff member and the implementation of the purpose and function was tracked by the senior management group through a range of measures including weekly reports and policy review groups. The manager and the director were separately satisfied that the purpose of the centre as they had envisioned it was implemented daily by the team, that the young people understood the nature of the centre and that the policies and procedures supported the work there. Inspectors found that there were some differences in the nuances of how the purpose and function was understood as met by the management and recommend that this be discussed in detail by them. The difference lay in whether this was a high support, high tolerance service or not. Inspectors also found that the purpose and function should feature more prominently in supervision and at team meetings for discussion and feedback from staff.

Inspectors spoke informally to two young people who both indicated that they liked the centre and were well supported by the team. The inspectors observed that the

two young people were comfortable and familiar with the manager and the director who were present at the time of the informal meeting.

The organisation has a policy review group and a policy review audit was in place including dates of completion (November 2018) and next date of review. A copy of the policy audit and updated policies and procedures was provided to inspectors and it was found that the policies were comprehensive and viewed as dynamic and live. The staff team had been inducted into any updated or new policies and procedures as applicable. Policies specific to the age range consent, use of CCTV and formal warnings had been added or revised in the policy document. The policy document layout relating to child protection and safeguarding had been made more cohesive and had been updated to accurately reflect the Children First Act 2015 requirements.

The centre was adequately staffed and was well managed to support its purpose and function and the records indicated that the staff provided a high level of support through daily planning and availability to the young people.

3.1.2 Practices that met the required standard in some respect only

None identified

3.1.3 Practices that did not meet the required standard

None identified

3.5 Planning for Children and Young People

Standard

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

3.5.1 Practices that met the required standard in full

Suitable placements and admissions

Inspectors examined the pre admissions process at the time of the three month inspection. It was found at that time that a well structured risk assessment based approach was completed for admission and saved to the young people's file. Upon re examination inspectors found that this system, which addressed control measures and protective factors, had been maintained in place. Inspectors recommend that perhaps a summary following completion of the pre admission risk assessment process as to the suitability decision, and a refinement of the risk rating system to allow for more prominent reflection of the most significant issues be considered. The manager added post inspection that no placements proceed until all social workers for the young people have reviewed and given input into the pre admission risk assessments.

The young people placed and those referred had varied and complex needs that impacted on their capacity to engage in a full preparation for leaving care package. Inspectors found that the manager was aware of this and aimed to tailor the individual planning to achieve progress in targeted areas and to support the young people toward an understanding of the challenges they faced and what supports were available to them now and in the future.

Inspectors observed a young person's version of the pre admissions process including a discussion of risks and self assessment of their life skills. There was other evidence on file of consultation with the young people and the two young people inspectors spoke to were clear about the centre and why they lived there but not necessarily for how long in one instance. The manager and staff had been supporting this young

person and advocating for them directly to the social work department and through inviting EPIC to meet the young person.

Discharges

Since the inspection in May 2018 there had been one young person discharged from the centre and despite efforts for this to be planned, a number of formal warnings and an escalation in risk in the community and to peers resulted in a discharge outside this plan. The formal warnings policy was implemented in accordance with the stated procedures and all parties had been informed of these.

Following this discharge the manager stated that the placement was reviewed and that learning from this was reinforced at team meetings. An exit interview was completed with the young person and the outcome of that was notified to the relevant parties. Inspectors found that discussion and review had taken place and learning had been promoted for all staff members. After receipt of the draft report the manager detailed the process in place around referrals and noted that significant learning from admissions/discharges was already informing their decision making in this area of their work. The manager also provided the inspectors with a copy of the revised discharge and formal warnings policy which had been updated and shared with inspectors in July 2018. During this inspection the copy of the policies and procedures utilised by inspectors did not contain this updated policy leading to an initial difference. This was resolved and acknowledged by the inspectors and this is reflected in the action plan attached.

For the purposes of accuracy one other discharge did take place where a young person from another centre required a placement for eight days before returning to their centre in April 2018.

3.5.2 Practices that met the required standard in some respect only

None identified

3.5.3 Practices that did not meet the required standard

None identified

Required Action

- The discharge policy and procedure must be updated to define more clearly timeframes and numbers of warnings that can lead to a discharge and what can lead to a warning being removed.

3.6 Care of Young People

Standard

Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

3.6.1 Practices that met the required standard in full

Managing behaviour

The centre had a range of integrated policies and procedures to support addressing behaviours that negatively impact the young people's lives and choices. The team were trained in a recognised method of behaviour management. The team were evidenced as inducted into the policies and procedures, and additional individual CPD style internal training sessions were completed on a range of areas by the manager. Staff had attended complementary training externally. The recent focus of the internal CPD sessions had been themed to a sound embedding of child protection and safeguarding procedures and knowledge. Inspectors were informed that the centre had the goal to not use restraint but that all staff are trained in a recognised method and were guided by risk management procedures regarding any eventualities that may require its use. The manager named that displays of aggression and bullying to peers or staff had not been a significant issue to date.

Each young person had a behaviour support plan, BSP, completed upon admission and reviewed thereafter at a monthly team meeting as required. Inspectors found that the BSP's were completed to a good standard and inspectors recommend that they be more specific where they need to be. The manager had sought input from the clinical team for one young person and this was referenced in their BSP. The young people also had a range of risk assessment and risk management planning documents linked to the BSP and the pre admission risk assessments which presented as operating as a coherent process. There was some evidence of young people being involved in this planning and inspectors found that the team structure their day to optimise points of contact and provision of support relevant to behaviour management.

Inspectors found that the system of behaviour management incorporated effective use of the significant event reporting system, use of natural consequences aligned to the model of care and a formal warnings process for serious risk impacting on a young persons or their peer's safety. Impact on the local community was also included in this and both had been a problem necessitating Garda involvement in recent months. At times apartment and pocket searches have been daily performed due to suspected drugs risks, the centre policies allowed for this response and young people had been informed. The centre worked in co-operation with external parties including the Gardaí in intelligence gathering toward the protection of young people. There was evidence of the manager advocating for strategy meetings where indicated as necessary. There was also evidence of co-operation with external agencies for specialised assessment and treatment options.

Despite the above actions there emerged a recurring theme of the need to manage significant risk from drugs and from suspected criminal activity. The manager and director indicated that this remained within the threshold of what the centre and team could manage. The measures in place to address the higher risk situations included first aid training, enhanced safety plans and on call support. Inspectors recommend that these issues be incorporated into a review of the determination of suitability given the learning acquired in this initial phase of the centres development. Post the issuing of the draft report the manager discussed this with inspectors highlighting the systems that they have in place for review of referrals, pre admission risk assessment systems and their overall governance systems that include opportunities to review and act on issues arising. Access to the company's clinical team is needs based and had been triggered prior to the inspection for one young person.

The centres register of risk assessments had 71 entries since March 2018 and the register included a review and outcome column, risk reduction was the goal and this was tracked on the register. A reduction in risk was achieved in a number of areas. Risk assessments relating to active risk, that remained unmitigated by specific intervention, for example suspected addiction issues, remained dynamic and specific whilst treatment and intervention was being sought. Inspectors also found that risk assessments had been used to inform a child protection reporting decision.

There had been two significant event review group (SERG) sessions completed and the records were available on file, one record involved the full group which included the CEO, the director, the regional manager and the managers of this and the company's other centres. The second was done at the centre by the manager and the

director with a staff member. Inspectors found that the two completed were comprehensive, linked to group and individual learning through team and management meetings and to supervision sessions.

The centre complete three monthly outcome progression reviews linked to the placement planning and care planning goals and at the time of the inspection the sample seen did not have a role in tracking challenging behaviours that impact progress. Inspectors recommend that the manager consider how the behaviour tracking and reporting is brought together in a way that is more holistic. The interim progress reports reviewed sometimes focused on reflecting the positives and strengths which is good but need to remain clear about true risks also.

3.6.2 Practices that met the required standard in some respect only

None identified

3.6.3 Practices that did not meet the required standard

None identified

3.7 Safeguarding and Child Protection

Child Protection

Standard

There are systems in place to protect young people from abuse. Staff are aware of and implement practices which are designed to protect young people in care.

3.7.1 Practices that met the required standard in full

The centres policy section had been updated to fully reflect the changes brought about through the full implementation of Children First 2015. Thirteen relevant and interrelated child protection and safeguarding policies were grouped together. These ranged from the child safeguarding statement to policies on safe practice, whistle blowing and training. Specific strategies and trackers for implementation of sound child protection knowledge and practice had been implemented and enshrined in policy. The staff team bar two pending had completed the e-learning required for Children First. Both staff completed this training since the inspection.

The centre had a register of child protection and welfare reporting forms that had been submitted, this contained nine entries and was commenced as a register in May 2018. Five were concluded through to a record that they were deemed not to have met the threshold for a child protection investigation, these determinations were listed as made by the relevant referring or allocated social workers. Where a decision had been made that a young person not be told that a child protection report form had been completed the reasons for this should be noted clearly. One report of an allegation against a staff member had been submitted and found not to meet the threshold for investigation. The matter was addressed well with all parties by the management and followed up for learning outcomes.

3.7.2 Practices that met the required standard in some respect only

Standard

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

The centre had a comprehensive and recently updated set of policies and procedures grouped together covering safeguarding and child protection. There was evidence of the manager's implementation of the policies with staff, provision of governance and oversight across all areas of team development, provision of supervision, team meetings, safety planning and overall team accountability for their practice. Safeguarding is a standing agenda item at the monthly management meetings.

Themed audits internal and external had been completed with the most recent external audit being done in May 2018. It would be advisable to complete more regular audits in the early stages of a centre's development in particular. The director was evidenced as involved in and knowledgeable regarding service delivery and the individual young people and they also delivered supervision in accordance with policy to the manager.

Since the last inspection two new staff had joined the team, one new full time staff member transferred from another centre and one new relief staff. Inspectors reviewed their personnel files and found that the updated vetting procedures agreed as part of the CAPA (corrective and preventative action plan) submitted following the last inspection had not been fully adhered to. The file that had been created prior to the action plan did not display verification of references, had no CV and no

verification of qualification. The second file had a copy of the certificate of qualification outstanding and did not contain a copy of a CV either.

Young people's rights were evidenced as promoted throughout policy and specifically in the complaints policy it was found by inspectors that a young person's right to complain to external bodies was supported. When a young person declined to pursue a complaint the manager and director led the staff in an internal review through to outcomes that then became incorporated into policy and practice. The manager had actively engaged with EPIC to invite them to the centre.

3.7.3 Practices that did not meet the required standard

None identified

Required Action

- The management must ensure that staff are recruited in line with the Department of Health circular 1994 and that all requirements are complied with before a staff takes up duties in the centre.

4. Action Plan

Standard	Issue Requiring Action	Response with Time Scales	Corrective and Preventive Strategies To Ensure Issues Do Not Arise Again
3.5	The discharge policy and procedure should be updated to define more clearly timeframes and numbers of warnings that can lead to a discharge and what can lead to a warning being removed.	The Formal Warning Policy was submitted to the inspectorate on 09.07.2018. During a full organisational policy review in November 2018, the formal warning policy was not printed to go on file with the new policy and procedures – however it was referenced for staff to refer to under the discharge policy. This was an oversight on management's behalf. Management have included the email correspondence to reflect this was completed on 09.07.2018 and a copy of the formal warning policy that was sent. In addition, this policy was further reviewed on 31.01.2019 and the update to this policy is also included with this report.	This was an oversight on the management's behalf. The formal warning process in the most recent organisation policy and procedure update in November 2018 did not include a separate section for formal warnings and this policy was linked to the discharge policy. The new update (Jan 2019) now has a one section for discharges and one section for formal warnings to ensure this issue does not arise again.
3.7	The management must ensure that staff are recruited in line with the Dept of Health circular 1994 and that all requirements are complied with before	New systems were developed following the previous inspection and on review of this process, it was deemed that too many people were overseeing organisation	A senior manager will oversee the recruitment of new employees to the organisation. No new employees will commence their post in a centre until all

	a staff takes up duties in a centre.	recruitment as tasks were allocated to different members of the management team. The systems in place will remain the same with a new governance system.	documentations are received and on file.