An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 161

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**TerraGlen Residential Services**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Announced**
Date of inspection:	**21st, 22nd and 24th June**
Registration Status:	**Registered from 26th September 2022 to 26th September 2025**
Inspection Team:	**Lorna Wogan** **Sinead Tierney**
Date Report Issued:	**30th August 2022**

Contents

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 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 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 26th September 2019. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from 26th September 2019 to 26th September 2022.

The centre was registered as dual occupancy to provide medium to long term care to two young people either male or female aged between 13 to 17 years. Their model of care was relationship based and was modified from pro-social modelling and attachment theories. 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
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.2
4: Health, Wellbeing and Development	4.2

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 20th July 2022 and to the relevant social work departments on the 20th July 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 4th August 2022. 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: 161 without attached conditions from the 26th September 2022 to the 26th September 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

The service provided to young people was person-centred. Young people were listened to and respected by staff and they were encouraged to express their views and wishes. They told the inspectors they felt safe living in the centre. The inspectors found that the young people's views and preferences in relation to daily living arrangements and decisions about their routines were taken in consultation with the young people. The voice of the young people was evidenced in the daily logs, progress reports, key working records, young people's meeting records and placement planning records.

Inspectors found that there was a culture of openness and transparency in the staff approach. Staff were open and honest with the young people in relation to their on-going care and how staff could support them in specific aspects of their lives. There were good systems in place for communicating with parents on a weekly basis and keeping them updated on their children's progress. There was evidence that parents were informed of significant events, unauthorised absences from the centre or complaints. The centre manager and senior staff were good role models for new staff in terms of how they listened to the young people and advocated on their behalf. The social workers and Guardian ad Litem confirmed this in interview with the inspectors. Staff listened to what the young people had to say about living together and this helped them feel safe and improve their experiences.

There was evidence of improved practices in the centre in relation to picking up on complaints and issues raised by the young people as identified in the centre's improvement plan developed from December 2021. The external line manager visited the centre on a regular basis and provided the opportunity to the young people to bring any concerns about their care to their attention. Young people were aware of how to make a complaint and complaints were acted upon in a timely manner and the resolution process was inclusive of the young people.

There were information booklets for parents and young people that outlined the complaints process in place and that staff were open to listening to and resolving any complaints or issues that may arise during the placement. The booklet signposted other organisations external to the centre such as EPIC and the Ombudsman for Children's Office that could provide additional support to young people in care. The inspectors recommend that the young people's information booklet should also include information about Tusla's complaints and feedback procedure '*Tell Us*'.

Both young people confirmed they were informed about how to make complaints and indicated that they had no complaints at the time of the inspection. One young person stated that they would go directly to their social worker if they had complaints about their care. The centre records evidenced that the staff supported the young people to access external services to resolve their complaints as appropriate.

The centre had a written complaints policy and complaints were categorised into non-notifiable and notifiable complaints. Notifiable complaints were in general more serious complaints that were forwarded to relevant parties as a significant event while non-notifiable complaints related to issues that could be resolved internally and at local level. The inspectors found that staff interviewed were not clear on the thresholds for the classification of complaints as notifiable or non-notifiable. Additionally, the inspectors found that the classification of the outcome of complaints required review as some complaints were classified as withdrawn when in fact based on the outcome of the complaint, they were upheld. The inspectors also found no evidence that the appeals process was offered to a young person when they were not satisfied with the outcome of their complaint.

A complaints log was maintained by the centre manager. Inspectors found there was good oversight of the complaints register and the complaints records. The complaints records were maintained on file and the centre records evidenced follow-up key working and feedback to young people following complaints made. Social workers were informed of notified complaints through the significant event reporting structure and where complaints were classified as non-notifiable the social workers were informed by telephone/email and through progress reports forwarded to them. Complaints were reviewed and discussed at team meetings and at management meetings where learning outcomes were identified and relayed back to the staff team.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must review with the staff team the thresholds for reporting complaints as notifiable or non-notifiable and ensure the outcome classifications are accurately recorded in line with the outcome findings.
- The centre manager must ensure that the complaint records evidence that the appeals process has been offered to the young person where they are dissatisfied with the outcome of the resolution process.

Regulation 5: Care practices and operational policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

There were comprehensive and well-developed policies to promote positive behaviour and policies to guide staff in the management of behaviour that challenges. Positive behaviour was acknowledged, praised, and reinforced in the centre and this was evident on the centre records. The use of sanctions to address negative behaviour was minimal. Staff were able to describe their approach to support positive behaviour and how they managed behaviour that challenges. Inspectors saw these approaches reflected across the centre records, in daily logs, significant event reports and in life space interviews. There was evidence of oversight, direction and support provided for staff in their work by the centre manager and the director of operations.

The admission records provided sufficient information for the centre to set out the behaviours of risk and concern and to develop appropriate support interventions for the young people to respond to their presenting needs. Care plans were up to date, and tasks identified were reflected in the placement plans on file and in key working undertaken with the young people. Each young person had a behaviour support plan to guide the team in the management of their behaviours and associated risks.

Pre-admission risk assessments were completed, and risk management plans developed on admission. Following a review of the pre-admission plans the inspectors recommend the managers review the risk scoring system as the scoring framework within its current structure did not always accurately reflect the identified risk. Additionally, the inspectors found that all of the risks identified in the risk assessment for the young person did not transfer over to the individual risk management plan yet some risks not relevant to the young person's presentation were incorporated into the risk management plan. The inspectors also recommend that the structure of the risk management plan is reviewed as the highest risks for the young people were not immediately evident on the risk management plans. A review of the pre-admission risk assessment pro forma along with the individual risk management plan as above would enhance the effectiveness and accuracy of the plans and ensure all identified risks were set out based on the level of the assessed risk.

Staff interviewed displayed a good understanding the potential causes of behaviours and this was observed throughout information contained on the individual care records. Safety plans were appropriately put in place when behaviours posed risk to the young people in the centre. These plans were based on good risk assessments and included suitable and responsive measures to reduce risks. Individual risk assessments on file were well structured and risks were identified, assessed and control measures outlined. The inspectors found that risk assessments were reviewed and closed off where the risk was no longer present.

Overall, the inspectors found that individual crisis support plans (ICSPs) were comprehensive and detailed and in line with the behaviour management approach. These plans were reviewed by the team and were updated monthly. In relation to one young person's ICSP there was conflicting information on the plan in relation to the use of restraint interventions. The centre manager must ensure this young person's ICSP is reviewed and updated to ensure there is absolute clarity in relation to the use or not of physical restraint interventions.

Each young person also had an individual absence management plan that was updated regularly. The inspectors found that the absence management plans contained detailed personal information about the young people and their family that was not relevant in responding to a young persons' unauthorised absence. The absence management plan for one young person did not outline all the agreed procedures for the young person's return to the centre. The other young person's plan stated they were not permitted free time when in fact staff informed the inspectors, they were permitted periods of free time in the community. The centre manager and key workers must review the absence management plans to ensure they are accurate and only contain information relevant to the risk of unauthorised absences from the centre.

There were systems in place to incentivise positive behaviour and assist the young people to develop positive routines. The staff had implemented a behavioural modification approach to assist one of the young people to meet their identified goals as set out in their care plan, placement plan and behaviour support management plan. The use of consequences in the centre was in line with the centre policy and consequences were documented on the care records with appropriate oversight by managers.

The inspectors reviewed a sample of significant event reports. The reports evidenced effective implementation of the behaviour management model in place and a good awareness by staff of the young person's behaviour. Life space interviews and key working evidenced staff supporting the young people to understand their behaviour and learn from events. There was evidence of key working following significant events to help the young people to connect their needs and feelings to their behaviour. The inspectors found there was good oversight and comments on the significant event reports from both the centre manager and the director of operations to promote a culture of learning and safety. The centre manager had access to an external specialist to advise, guide and support the care approach in the centre. This was a beneficial resource for the manager.

The director of operations and the director of services had undertaken audits of the centre's practices in relation to managing behaviour that challenges. There were systems in place to ensure regular oversight and monitoring of the records in relation to incidents. Required actions were identified in audits and dates of completion of required actions identified. Significant event review meetings were undertaken monthly, and they were attended by staff, internal managers, and external managers. There was evidence that significant event review meetings provided a detailed,

honest, and transparent analysis with clear learning outcomes identified. There was a focus on the implementation of the model of care, the ICSPs and a review of risk assessments and risk ratings where required following the review meeting.

The centre had a well detailed policy on the implementation of restrictive practices. There was one restrictive practice in place in the centre where alarms were placed on bedroom doors. The inspectors found that this practice was previously risk assessed however the risk assessment was not updated for the current resident group. The centre manager must update the risk assessment for this restrictive practice to evidence its on-going requirement in the context of the current resident group.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager and the director of operations must review the pre-admission risk assessment pro forma along with the individual risk management plan to build on the effectiveness and accuracy of the plans and ensure all identified risks are set out based on the level of the assessed risk.
- The centre manager and keyworkers must review the ICSPs and IAMPs to ensure they are accurate and reflect the current responses to the young people. Personal information not relevant to the absence management plans should not be recorded on the plan.
- The centre must ensure the risk assessment for the restrictive practice in place in the centre is updated to reflect it has been assessed as required for the current resident group.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The inspectors found the staff were aware of the needs of the young people and supported them in relation to their general health and wellbeing. The young people's health and development needs were identified on admission and promoted in the centre. Interventions and supports were provided to them in line with their care plans and placement plans. Social workers and the Guardian ad Litem appointed to one of the young people told the inspectors that the staff and managers were supportive of the young people and understood their needs in relation to their health and wellbeing.

The young people were registered with a general practitioner (GP) and had access to dental and optical care services when they needed them. The centre worked closely with health care professionals to promote the young people's health and wellbeing. Records were maintained of all medical/specialist appointments and the outcome of these. Medical consent for one young person was on file however, the medical consent on file for the other young person was invalid as the incorrect name was input on the consent form. Young people were offered access to therapeutic supports if they needed such support. Overall, the inspectors found there was a good focus on the young people's physical, emotional, and psychological wellbeing.

Staff had systems in place to ensure that meals were nutritious and well balanced. They placed strong emphasis on healthy eating and limited the young people's access to unhealthy snacks in the centre. Despite this the inspectors found that one young person continued to consume a significant level of high sugar content foods they purchased with pocket money and money earned through centre-based incentive programmes. This requires review by the centre manager in consultation with the social worker and Guardian ad Litem. The inspectors found that issues relating to the health and wellbeing of the young people were managed in a sensitive, supportive, and caring manner. Staff were alert to the health risks for each of the young people and referred the young people to the appropriate specialist services. Inspectors reviewed the health needs of the two young people and found their needs were identified and addressed in a timely way. Key working records also showed that young people were supported to develop knowledge and understanding around their

health, including sexual health. Key working and individual work sessions with the young people were undertaken on a range of health-related topics. The inspectors acknowledged the efforts made by staff to support the young people to avail of medical services in a manner that met their needs.

Comprehensive medication management policies and procedures were in place to support good practice in relation to medication storage, administration, and disposal. Staff were trained in the safe administration of medicines. Systems were in place to ensure that medicines for young people were well managed. Regular medication audits were undertaken, and the inspectors advise that the date of completion of these audits is evidenced on the record. Medication records were maintained for each young person. Medications were stored in a secure manner in the centre.

There was one medication error identified in May 2022. While this error did not have a negative impact on the young people, it was promptly identified and subsequently discussed with staff and changes were made to ensure the safe administration and management of medications. On review of the centre medication folder the inspectors found medication administration records relating to a former resident. The director of operations had oversight of the medication folder which was last reviewed by them in July 2021. The inspectors recommend more regular oversight of this folder by the external managers.

Compliance with regulations	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure a valid medical consent form is placed on file for one of the young people in placement.
- The director of operations must ensure more regular oversight of the centre's medication folder.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must review with the staff team the thresholds for reporting complaints as notifiable or non-notifiable and ensure the outcome classifications are accurately recorded in line with the outcome findings. The centre manager must ensure that the complaint records evidence that the appeals process has been offered to the young person where they are dissatisfied with the outcome of the resolution process.	As some of the team members are new, the Social Care Manager will discuss the complaints Policy at the next team meeting in July 2022 to ensure the team have a clear understanding of notified and non-notified complaints. The Director of Operations has updated the complaints form template with the addition of a section regarding the appeals process added immediately post inspection.	When a new staff join the team, the Social Care Manager will refresh the complaints policy within team meetings and supervisions to ensure understanding of same. As the complaints form has been updated to add the appeals process, this section will have to be filled in with every complaint, which in turn will ensure this issue will not arise again.
2	The centre manager and the director of operations must review the pre-admission risk assessment pro forma along with the individual risk management plan to build on the	The Director of Operations is currently reviewing the preadmission risk assessment and going forward this will be completed based on the level of risks, for example, all high-risk behaviours at the	Due to the risks being recorded as per level of risks, this will ensure no risks/behaviours are missed which in turn will build on the effectiveness and accuracy of the document.

	effectiveness and accuracy of the plans and ensure all identified risks are set out based on the level of the assessed risk.	beginning of the document, then medium, and then low, and no behaviours that are not evident will be added to the report. Completion date September 2022.	
	The centre manager and keyworkers must review the ICSPs and IAMPs to ensure they are accurate and reflect the current responses to the young people. Personal information not relevant to the absence management plans must not be recorded on the plan.	Both the ICSP and IAMP have been reviewed and amended immediately post inspection as advised.	Required action completed.
	The centre must ensure the risk assessment for the restrictive practice in place in the centre is updated to reflect it has been assessed as required for the current resident group.	Completed the update of the Risk Assessment for restrictive practice of the centre alarms for current young people in the centre.	Review the restrictive practice policy and add in a section regarding the centre alarms to ensure this issue doesn't arise again.
3	The centre manager must ensure a valid medical consent form is placed on file for one of the young people in placement.	The Social Care Manager has sent consent forms to the Social Work Department for completion immediately post inspection. All documentation from previous resident	Ensure all data and templates of young people, once discharged, to be removed from all computers and the google drive.

		had been removed from the google drive, however the templates were not updated at the time of the inspection. This was rectified immediately in response and all new templates downloaded.	
	The director of operations must ensure more regular oversight of the centre's medication folder.	A scheduled date in July 2022 had been added for an audit of the centre files, including medication folder.	The Director of Operations to ensure reviews of centre folders are incorporated into the scheduled centre audits.