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: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Terra Glen Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**14th, 15th and 16th August 2023**
Registration Status:	**Registered from 26th September 2022 to 26th September 2025**
Inspection Team:	**Lorna Wogan** **Paschal McMahon**
Date Report Issued:	**20th October 2023**

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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 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 second registration and was in year one of the cycle. The centre was registered without attached conditions from 26th September 2025.

The centre was registered to provide dual occupancy, medium to long term care for young people aged 13 to 17 years on admission. The model of care was described as a relationship-based model adapted from pro-social modelling and attachment theory. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 7th September 2023. 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 22nd September 2023. 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.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

The inspectors found there were clear and robust systems in place to safeguard young people living in the centre and to ensure their care and welfare was protected and promoted. The centre had a Child Safeguarding and Child Protection Policy in place that was in line with Children First and relevant legislation. There was an in-service training module for staff to ensure they were familiar with the centre policy and the requirements of the legislation as it applied to their role. There was a comprehensive questionnaire to test staff knowledge of safeguarding and child protection and inspectors found evidence that this was completed with some staff to date. Staff completed Tusla's e-Learning programme Introduction to Children's First prior to commencement of employment and while all staff interviewed were aware of their statutory responsibilities as mandated persons the inspectors recommend that all staff complete Tusla's Mandated Persons e-Learning training programme which is available on the Tusla website. Staff interviewed were aware of how to submit a welfare or child protection concern though the Tusla portal and were aware of their responsibility as mandated persons to report such concerns. Staff were confident they could make a mandated report independent of their designated liaison person. The reporting procedure for child sexual exploitation (CSE) was displayed on the staff notice board and incorporated into the centre's policy document. There were some gaps in training for newly appointed staff however the managers interviewed stated this training was scheduled to take place.

The centre had their child safeguarding statement displayed in centre and staff interviewed were familiar with its purpose and content. The centre manager was named as the designated liaison person (DLP) on the statement and had completed specific training in relation to this role. The deputy manager was the identified deputy DLP. A list of all mandated persons was set out on the child safeguarding statement. Staff interviewed were familiar with the categories of abuse, the potential risk of harm for young people living in the centre and the mitigation measures identified on the statement.

Staff were able to identify the centre's safeguarding policies and the specific safeguarding practices in place to promote safe care. They identified safeguarding policies and practices such as safe recruitment practices, lone working policy, staff code of practice, anti-bullying policy, supervision and staff training. The staff code of practice was displayed on the office notice board however four staff members only signed it. The centre manager must ensure the staff code of practice is verified as read by all staff members.

The centre had an anti-bullying policy. The inspectors found that staff were alert to bullying and incidents of bullying within the centre were appropriately reported and managed. There was evidence that bullying behaviour was identified in a prompt manner and notified as a significant event. Where incidents of bullying were assessed as meeting the threshold of harm it was reported under Children First. There was ample evidence that the staff undertook individual work with both young people where incidents of bullying were observed. There was also good oversight of the group dynamic and incidents of bullying were reviewed at in-house management meetings. Additionally, the newly appointed manager requested that staff ensure bullying was a consistent item agenda at the house meetings with the young people.

There were forums in place to review specific high level significant events (SERG meetings). There was evidence of identification of learning and review of staff interventions and staff practice in the SERG records and team meeting records. SERG meetings were attended by the centre manager, team members and the director of operations. There were four SERG meetings in 2023 to review patterns of incidents and serious incidents as they arose.

There were no on-going concerns in relation to inappropriate use of social media or the internet. Individual work around appropriate use of social media and the internet was evidenced as completed in individual work and key working. There was one recent incident of concern for a young person in relation to inappropriate communication on the phone. This was appropriately identified and reported by the staff as a significant event and a mandated report was submitted. The allocated social worker confirmed they planned to follow up and investigate the concern and would liaise with the young person's parents to inform them about the incident.

Areas of individual vulnerabilities for the young people were evidenced in their care plans, placement plans, progress reports, risk assessments, behaviour support management plans and absence management plans. There was ample individual

work and key work on file completed with the young people to develop self-awareness and safety mechanisms to support their safety. Staff provided clear messages to the young people in relation to their safety and set appropriate boundaries and expectations for the young people to safeguard them. Staff interviewed were confident the young people would speak out if they were feeling unsafe and provided examples of this to the inspectors. The external professionals interviewed by the inspectors confirmed that there was effective communication and collaborative work to safeguard the young people. The social workers interviewed by the inspectors were satisfied that both young people had made significant progress since their admission to the centre.

Mandated reports (CPWRFs) were maintained on file with accompanying tracking number and emails to evidence follow up on the status/outcome of the reported concerns. There was evidence that the director of operations consistently followed up on reported concerns and this was confirmed by the social workers. The centre's child protection register was maintained up to date with evidence of whether concerns were closed and/or the action taken to date. Reported child protection concerns were reviewed in the in-house management meetings also. There were two current child protection concerns on the records that were subject to Garda investigations. On one of the mandated reports reviewed it was not clear to the inspectors what specific concern of harm/abuse was being reported. Staff making mandated reports must identify on the report the specific welfare or child protection concern/risk of harm and the potential category of abuse/harm that is the subject of the reported concern.

An audit under Theme 3 of the National Standards for Children's Residential Centres (HIQA) 2018 was undertaken by the director of operations and a senior manager external to the centre in May 2023. Areas of strength, goals for growth and timescales for completion of identified gaps were set out in the compliance audit document. There was evidence on the audit document that some of the required actions were met and others were being progressed at the time of the inspection.

There was a protected disclosure policy in place. Staff were aware they could make a protected disclosure and that they could do this without fear of any adverse consequences for themselves. There was lack of clarity in relation to who was the 'authorised person' within the organisation as per the protected disclosure policy however staff informed the inspectors, they could take concerns up through the line management structure or to named external bodies. There were no protected disclosures in service since last inspection.

Compliance with Regulation	
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 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure the staff code of practice is verified as read by all staff members.
- The centre manager or staff making a mandated report must ensure that such reports specifically identify the welfare or child protection concern and the potential category of abuse/harm that is the subject of the reported concern.
- The director of services must ensure that the services protected disclosure policy identify who is the 'authorised person' to receive such disclosures and staff must be informed of this person and their role.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The governance structure was in transition at the time of the inspection with the departure of three directors earlier in 2023. In the interim the CEO was covering the director of services role and responsibilities and the newly appointed director of operations was covering the quality assurance directorate with assistance from a senior centre manager within the service. However, despite the departure of senior personnel the inspectors found there was no decrease in the level of governance,

leadership and oversight of the centre since that time. The current director of operations, who was formerly the centre manager for this centre, was familiar with the needs of the young people and the operation of staff team. The director of operations commenced in this role in February 2023 and had, to date, provided high-level oversight, guidance, direction and support to the acting centre manager and the staff team. There was evidence of regular visits to centre, additional visits following high-risk events, completion of a compliance audit and spot inspection, attendance at all professional meetings, attendance at SERG meetings and at several team meetings. There was evidence of their review and comments on significant events that occurred. The CEO had also visited the centre and undertook a walkabout of the premises with the newly appointed centre manager to assess the standard of the physical environment and approve decorative upgrades. The director of operations stated that the CEO was accessible to them and there was regular communication and systems in place for sharing information.

The centre manager was appointed two months prior to this inspection. The centre manager had considerable experience both working with young people in residential care and in management and was appropriately qualified to undertake the role. They were responsible for the overall delivery of the service. The deputy manager previously managed the centre in an acting capacity from February to June 2023 and provided strong leadership and robust oversight of practice during this time therefore there were no gaps for staff in terms of leadership within the centre. Overall, the records evidenced an expectation of high standards of practice and accountability at all levels in the centre and opportunities for staff to be supported in their learning and development. There were a range of governance systems in place from weekly governance reports, fortnightly team meetings, in-house management meetings, monthly managers meetings, audits and spot inspections that evidenced oversight of practice and leadership. The internal management structure was appropriate to the size and purpose and function of the centre with three social care leaders and a deputy manager, however at the time of the inspection one of the social care leaders was on extended leave and there were only two social care leaders on the team. Internal social care leaders' posts were advertised across the service at the time of the inspection. There were alternative management arrangements in place for when the centre manager was absent from the centre and this role was covered by the deputy manager. The staff interviewed by the inspectors and additional staff the inspectors engaged with in the course of the inspection stated there was strong leadership in the centre. They stated they also received good support guidance and direction in their work as well as being held to account for their practice. Social workers interviewed

also commended the centre managers in term of their accessibility and effective communication.

There was evidence that policies and procedures were reviewed and updated as required by senior management and discussed with staff members in team meetings. The current suite of policies and procedures were aligned with the National Standards for Children's Residential Centres (HIQA) 2018 and current relevant legislation.

There was a risk management framework in place in the centre. There were robust systems in place for managing risk in line with centre policy. There was evidence that staff received training on the centre's risk management framework however newly recruited staff had yet to complete this training. The staff interviewed were familiar with the risk assessments in place to mitigate risk and respond to the young people's vulnerabilities. Individual risk assessments and risk assessments on active restricted practices were evident and well organised on the care files. There was evidence of risks identified and assessed on their risk matrix with control measures in place. Current risk assessments were subject to regular reviews at team meetings where the risk was either reclassified, moved to their behaviour support management plan or closed out. Active risk assessments were easily identifiable on file for staff. Staff interviewed were confident they could competently complete dynamic risk assessments if required. Risk assessments and risk registers were subject to a spot inspection in July 2023 undertaken by a senior manager external to the centre. Social workers interviewed were confident that the team were alert to risk, responded to it effectively and consulted with them and forwarded all supporting documents relating to managing risk. The inspectors found that the organisational risk register did not identify or assess the impact of staffing deficits on the day-to-day operation of the centre.

The service was contracted with Tusla' National Private Placement Team and met with them annually to review contracting arrangements.

The centre maintained a task list that set out specific roles and responsibilities that were assigned to staff. This was displayed in the office. There was evidence that specific roles assigned to staff were discussed in staff supervision and in team meetings.

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

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

Actions required

- The service directors must assess the risk to the day-to-day operation of the centre associated with staffing deficits and incorporate it into their organisational risk register.

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 centre statement of purpose stated that the staff complement comprised of the centre manager, deputy manager, three social care leaders, five social care workers and four relief staff. At the time of the inspection one of the social care leaders had resigned from their post and one staff member was on extended leave. There were two relief staff available to the centre and both these staff were working on the staff rota to cover staff shortages. Agency staff were also used to cover the duty roster. The director of operations received confirmation from the agency regarding the vetting of agency staff. The deputy manager also covered the duty roster as required. There was evidence of a recent recruitment campaign and notices displayed advertising internal leadership posts. The staff interviewed confirmed there were opportunities to progress within the organisation. There was evidence that workforce planning was discussed at the monthly managers meetings. A review of the staff rosters and interviews with staff indicated that staff were not expected to undertake additional shifts and undertaking double shifts was not supported by management

and was not a regular practice in the centre. There was evidence that the managers arranged the staff rota to ensure that newly appointed staff worked alongside more experienced staff. There was evidence of a willingness amongst experienced staff to support the shifts to ensure safety for all.

Staff recruitment and staff retention was a challenge for the organisation. Eight staff members had left the centre since the last inspection in June 2022. The rosters were reviewed over a period of six months and showed that four agency staff were used to cover shifts and two staff from another centre within the organisation. There was evidence that staff turnover impacted the young people. On the day of the inspection one young person expressed their dissatisfaction about the changes and turnover of staff. The staff were conscious of this and the reasons why staff left was explained to the young people in individual and key working sessions. There were a variety of reasons why staff left. Two staff were promoted internally and moved to other centres, two staff left to travel, three staff moved to work locations nearer their homes and one staff member left the social care sector. There was a system in place to conduct exit interviews. Senior managers external to the centre conducted these interviews. Only one staff member had left the centre since the director of operations had commenced in their role and an exit interview form was sent to them to complete but had not yet been completed and returned. The director of services should consider undertaking a staff exit interview before the staff member leaves the service.

The staff had a range of related qualifications however the current staff vacancies must be filled by applicants that hold a recognised social care qualification in line with the ACIMS Regulatory Notice - Minimal Staffing Level & Qualifications CRC Settings, June 2023. Apart from the deputy manager there were only two staff members that held a social care qualification.

The centre manager had recently undertaken an audit of the staff personnel files and identified a number of gaps in the required documentation however there was no evidence on the audit as to how or when these gaps would be rectified. Similar gaps were identified by the inspectors such as verification of qualifications for two staff members, only two written references on file for another staff member (however there was evidence of three verbal reference checks) and no evidence of verbal checks on references for another staff member. The inspectors also found that in instances where references highlighted some deficits in performance this was not evidenced as assessed by the director of service and the centre manager or that additional support and supervision structures were identified to address the identified performance issues. The inspectors found that refresher training in the centre's behaviour

management model was not up to date for a number of staff members and for some staff was out of date by a significant number of months. Refresher training for July 2023 was re-scheduled and was planned to take place end of August 2023. This training must be prioritised for all staff members.

There was a supervision policy in place and on review of staff supervision files there was evidence that staff were supported to reflected on their practice, review their training needs, their work with the young people and there was evidence of accountability for practice. The inspectors found that for some staff the frequency of their supervision was not in line with the centre policy. There were some significant timeframe gaps in supervision for some staff. The centre manager must ensure staff supervision occurs in line with the policy. There was evidence of professional development plans for some staff to support their learning and development.

There were formalised procedures in place for on-call arrangements at evenings and weekends. On-call support was shared across two centres with social care leaders, deputy managers and centre managers providing the out of hours supports. A record was maintained of all on-call advice and decisions taken. The person on call was identified on the staff roster each day.

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 of services must ensure that vacant posts are filled by staff who have a recognised social care qualification in line with the requirements of the ACIMS Regulatory Notice - Minimal Staffing Level & Qualifications CRC Settings, June 2023

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure the staff code of practice is verified as read by all staff members.	Each staff member of the staff team has read and signed the document. This was completed by 19th September 2023.	As each new team member joins the team this will be strictly part of their induction. This will also include all agency staff who may work in the centre.
	The centre manager or staff making a mandated report must ensure that such reports specifically identify the welfare or child protection concern and the potential category of abuse/harm that is the subject of the reported concern.	This was addressed at the team meeting 20.09.2023. The centre manager will ensure that all staff are fully briefed on the correct procedures and identifying risks. The child protection policy will be reviewed in this regard.	The centre manager will review at team meetings going forward to ensure all staff are aware of policy and procedure.
	The director of services must ensure that the services protected disclosure policy identify who is the 'authorised person' to receive such disclosures and staff must be informed of this person and their role.	The protected disclosure policy will be updated by early November 2023 to reflect same.	Senior management will ensure a review of policies is completed on a regular basis, so all updates are completed within projected timeframes.

5	The service directors must assess the risk to the day-to-day operation of the centre associated with staffing deficits and incorporate it into their organisational risk register.	A risk assessment was completed and put on file in relation to staffing deficits and the impact this can have on the team and young people. Completed on 14th September 2023.	Senior management to ensure all centres are risk assessed in relation to staff deficits when and where applicable, identifying clear action plans to manage and mitigate the identified risks.
6	The director of services must ensure that vacant posts are filled by staff who have a recognised social care qualification in line with the requirements of the ACIMS Regulatory Notice - Minimal Staffing Level & Qualifications CRC Settings, June 2023.	The centre is aware that vacant posts must be filled by staff with a recognised social care qualification to be in line with the requirements of ACIMS Regulatory Notice, June 2023, and we will only interview for social care qualified staff to ensure the centre has the correct ratio of staff with a social care qualification.	The centre has always ensured it maintained the required percentage of team members with a social care qualification. However, due to the staff who left the centre who held a social care qualification this left the ratio altered. The service is aware and acknowledges the focus of recruitment for this centre will be to recruit staff with a social care qualification.