An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 166

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Harmony Residential Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Blended Announced**
Date of inspection:	**05th and 06th October 2021**
Registration Status:	**From the 12th of April 2020 to the 12th of April 2023 with attached conditions**
Inspection Team:	**Cora Kelly** **Eileen Woods**
Date Report Issued:	**15th February 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 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 12th of April 2020. At the time of this inspection the centre was in its first registration and was in year two of a three-year cycle. The centre was registered without attached conditions from the 12th of April 2020 to the 12th of April 2023.

The centre was registered to provide care and accommodation for up to four young people aged between 16 and 17 years of age in order to prepare them for leaving care. Their model of care was described as informed by a therapeutic based approach of cognitive behaviour therapy that focused on the total behaviour of the young person. 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
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 22nd of October 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 4th of November 2021. Further revisions of the CAPA were completed with the final CAPA received on 19th November 2021. It was the inspector's findings that the CAPA was deemed not to be satisfactory as the responses did not detail sufficiently how actions would be met.

The findings of this report and assessment of the submitted CAPA deem the centre to be not continuing to operate in adherence with regulatory frameworks and standards in line with its registration. The inspection report was discussed at the registration committee on the 10th of December 2021 and at this time, it was the decision of the registration committee to add the following condition to the centre's registration from the under Part VIII, Article 61, (6) (a) (I) of the Child Care Act 1991:

- The corrective and preventative action plan is to be fully implemented so that the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 5, *Care Practice and Operational Policies*.

The condition to the registration will commence on the 4th of January 2022 and will be reviewed on or before 31st of March 2022.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

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 care plans on file for both young people residing in the centre. They were found to reflect their current placement, contained detailed descriptions of their assessed needs that were followed by action plans for implementation by both the allocated social workers and staff in the centre within a set timeframe. There was evidence of the centre requesting care plans from one of the young people's social workers when they were experiencing a delay in receiving it following their child in care review (CICR). Statutory CICR's were found to have been held in line with regulations. Young people were encouraged to attend their CICR meetings with the support of their keyworker and centre manager. If they chose to not attend, they were supported to complete review forms with specific pieces of keyworking also undertaken with the young people. Clear arrangements were in place in ensuring that feedback on meeting outcomes and decisions made was provided to the young people. Additional good care planning arrangements were in place for one of the young people with multidisciplinary meetings being held monthly to track their progress and this enabled good planning across their assessed areas of need.

There were up-to-date placement plans in place for both young people. These were based on their care plans and other needs identified by staff. With their keyworkers, young people were encouraged to participate in the development of their placement plans and identify their own goals to work on and achieve. Placement plans were reviewed monthly at internal case management meetings that were led by a social care leader and were discussed at team meetings. There was evidence of the three-monthly placement plan and outcome progression reports being completed. Placement plans goals were set out across eight areas: family access, peer access, independent and group living, education and training, hobbies, budgeting, emotional and behavioural and life skills. A six-step approach was used to measure outcomes across the eight areas. There was a lack of detail regarding who in the centre had been identified to implement and achieve the goals detailed in the placement plans. The inspectors recommend that staff members are nominated to complete specific

pieces of individual work as per goals outlined in the placement plans. There was evidence of clinical input being sought by the centre to assist the staff team in responding to an issue presented by one of the young people. A similar process had commenced for the other young person.

Both young people had keyworkers and staff were clear of their roles as keyworker and case manager in interview. The inspectors observed some keyworking and a variety of individual work records that were connected to the placement plans and care plans.

It was evident that there was a good focus on family access and of staff supporting the arrangements in place for the young people. In conjunction with care plans and placement plans young people were being supported and facilitated to access external supports in consultation with social workers. Inspectors found evidence from records of clear communication with social work and of clear communication between the centre and young people's social workers. Social workers were provided with updates regularly, were also provided with weekly reports and received notification of significant events. Social workers visited the centre regularly and there was evidence of them reviewing young people's files during these visits. One of the young people had a Guardian ad Litem appointed to them. In interview the guardian spoke positively of the progress the young person had made to date and that their relationship with staff was positive and was contributing to this progress.

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

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

Actions required

- None identified

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.

There had been numerous changes in centre management since the last inspection by the Alternative Care Inspection and Monitoring Service (ACIMS) in September 2020. From early 2021 to August 2021 a total of three centre managers were appointed to the position in acting capacities whilst senior management within the organisation were finalising arrangements for a full-time centre manager. The previous centre manager had resigned from their post early 2021. The current manager was appointed to the centre in August 2021. The inspectors were informed by the director of social care that this was a temporary arrangement and that they will be returning to their previous post as assistant regional manager in May 2022. It is envisaged by the organisation that by this stage the current deputy manager will have the appropriate qualification for the centre manager position. All three individuals had previously been part of internal management structures in the centre. The inspectors found from the review of centre documentation that staff had expressed their concerns at the level of change in centre management. These were responded to by senior management with additional support and oversight provided to them by the regional manager. Senior management must demonstrate their accountability by ensuring that a stable centre management structure is maintained in the centre that assures consistent leadership, governance and management will be provided to the staff team.

Inspectors found the change in management did impact on consistent leadership and management being provided to the staff team and young people in the centre given individuals different management styles and approaches. This impact was evident from the inspectors review of records that related to monthly team meetings, internal management meetings, case management meetings and daily logs and handovers. It was found that records were not being consistently signed by staff and management, some signatures were illegible, actions were not being tracked from month to month, staff names were not recorded on daily logs or not all staff on shift were being recorded on the daily handover records. It was further found that updated records of

staff rosters were not kept by centre management, just original templates of planned roster for the month. This is preventing the centre from tracking staff and any last-minute related types of leave taken. It is the inspector's finding that this is a safeguarding issue, and the centre must retain accurate records of staff that were on shift in the centre. The template for the team meetings was updated following the ACIMS inspection in September 2020 to include complaints, significant event reviews and child protection concerns. However, records of discussions did not correlate with these and other agenda items. Going forward the centre manager must strengthen their leadership and management role in the centre including record keeping practices to address the deficits outlined above.

The centre manager, as the appointed person in charge held responsibility for the overall running of the centre. They were present in the centre Monday to Friday from 9am to 5pm. In interview the centre manager was clear on their role and responsibilities in providing clear, effective and safe care to the young people. They had previous centre manager experience in another centre within the organisation prior to their appointment as assistant regional manager in May 2021. In interview, they stated their leadership would be demonstrated at team meetings, internal management meetings, attendance at daily handovers, supervision, and ongoing presence in the centre. Governance mechanisms included the completion of monthly manager reports, internal audits, and weekly reports. Staff in interview stated that the current centre manager was providing good leadership and was available for support and guidance.

There had also been changes to senior management structures and governance arrangements within the organisation that filtered through to the centre. The revised arrangements included the centre manager reporting to the director of social care as their line manager through telephone calls, reports and emails and received supervision from them. The previous structure included the centre managing reporting directly to the assistant regional manager. In conjunction with the organisation's regional manager a layer of senior management had been subsumed to centre management positions due to staffing issues within the organisation. This arrangement had resulted in senior management meetings being suspended, the organisations policy review group on pause and was leading to deficits in the auditing of centre practices. Oversight mechanisms in place were being provided externally by the director of social care. They were undertaking their duties remotely with the CEO of the organisation visiting the centre regularly. Their oversight of centre and staff practices was provided on weekly reports and monthly managers reports. The

inspectors observed comments recorded by them during their review of related records.

The inspectors identified deficits regarding the centre's internal auditing arrangements. Several audits of centre records had been completed by the deputy manager in 2021. These audits assessed whether records were in place for example team meeting minutes, young people meeting minutes, an audit of centre registers and the management folder. Deficits identified by the deputy manager included a lack of staff oversight across team meeting and young people meeting minutes. It was recorded that no issues arose from the review of centre registers. This audit approach did not yield outcomes on the quality and safety of care provided in the centre. The external themed audited that was completed in June 2021 by the regional and assistant regional managers was in compliance with their own auditing arrangements. In interview the director of care stated that they would be commencing audits the month following this inspection.

The service level agreement with the funding body Tusla was signed in the week before this inspection. Meetings between the organisation and Tusla are scheduled to take place bi-yearly.

As part of the organisation's process a review of the organisation's policies and procedures was completed by the regional manager and director of social care in February 2021. Since that time some policies had been updated including induction, complaints, code of conduct and on-call.

The centre's policy on risk assessment lacked details relating to internal and external escalation processes, procedures for risk assessment review mechanisms and did not describe the risk matrix utilised as part of risk assessment processes to determine the levels of risk. Staff in interview were able to describe daily and ongoing practices that related to risk identification, assessment and management. This included pre-admission individual risk assessments, group impact risk assessments, general individual risk assessments, behaviour support plans, risk management plans, absence management plans and practice guidelines. The inspectors identified deficits in some risk assessments being completed based on information received at pre-admission risk assessment stage of admission for e.g., suicidal ideation behaviour for one of the young people. It was found that all risk assessments were not consistently reviewed to determine if the risk assessment was ongoing or closed. A centre risk register was not in place, rather a register of risk assessments, nor was an organisational risk register in operation. The inspectors are aware that following an

ACIMS inspection of another centre within the organisation in September 2021 two actions from the inspection required the organisation 'to develop a risk assessment framework and ensure it contains the necessary supporting structures in place for the identification, assessment and robust management of risk' and 'put in place centre and organisational risk registers with the necessary review mechanisms to support ongoing review of risk'. Since that inspection, risk registers have been added to the standing agenda of external management meetings. For this inspection a centre risk register must be developed with risk assessment review processes to support the ongoing identification, assessment, and management of risk.

In interview individual staff team members were clear on the current structures within the centre and organisation and of their roles and responsibilities. Internal centre management comprised of a centre manager, a full-time deputy manager and three social care leaders one of whom is due to move to a deputy manager position in another centre within the organisation and another staff returning following a period of leave both occurring the week following this inspection. The deputy manager was the appointed person to act up in the centre managers absence. A written delegation of tasks record was in place.

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

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

Actions required

- The registered provider must demonstrate their accountability in ensuring that a stable centre management structure is maintained in the centre that assures consistent leadership, governance and management will be provided to the staff team.

- The centre manager must strengthen their leadership and management role in the centre including record keeping practices that address the deficits outlined in the report.
- The director of care must ensure the continuation of external auditing arrangements in the centre.
- Centre management must develop a risk register to include risk assessment review processes to support the ongoing identification, assessment and management of risk.

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.

There were appropriate numbers of staff employed in the centre in line with the centre's statement of purpose and was suitable to the needs of the two young people in placement. The centre manager was supported by a deputy manager, three social care leaders and six social care workers. Nine staff members were appropriately qualified with two qualified in a related field. A relief panel that was shared between all five centres in the organisation was available to support the staff team when required. Staff stabilisation was found to have occurred during the times of changes within centre management.

Workforce planning for the centre included the staff rota, provision of ongoing supervision and training and development with some level of discussions at external management meetings. It was observed that the training and development needs of staff was not discussed at these meetings. There was evidence that the centre was experiencing a deficit in workforce planning and that it was affecting the young people. The movement of staff out of the centre, before staff commencing shifts or during shifts, to facilitate emergencies in other centres within the organisation had occurred on four occasions during the months of August and September 2021. It was recorded on the informal complaints register that two young people had made five informal complaints about this practice. A former young person made two informal complaints and a current young person making three after which they made a formal complaint in September 2021. The complaint was responded to internally by centre

management with the director of social care, as complaints officer, providing their view on how the complaint was managed. The management of the complaint included it being reported to the relevant professionals through the notification of significant events system, the record which the inspectors viewed. The young person was informed that centre management would aim to reduce the incidences of the movement of staff occurring. A similar response had been issued to the young person following their informal complaints. It was evident that the young person was not satisfied with the outcome to the formal complaint and stated that they would make another complaint if the issue continued. It is the inspectors view that this was not a child centred approach, and further, it would have been an opportunity to involved their social worker to investigate the complaint on her behalf. In interview, both the centre manager and the director of social care informed the inspectors that the complaint was closed. It is the inspectors' findings that the informal and formal complaints relate to care being provided to young people in the centre. For the purposes of transparency, accountability and safety the centres response to both types of complaints require review to ensure that they are investigated by appropriate professionals and that a more satisfactory response is provided to the young person. The centres complaints policy must be examined as part of this review.

Centre management were tasked with devising the staff rota. As the centre was not in the practice of storing updated staff rotas the inspectors were not able to track how often staff were swapped out with staff in other centres and if the swapping of staff was due to staff safety or staff shortages. The director of social care must ensure that there are effective organisational workforce planning mechanisms in place that prevents the movement of staff from this centre to facilitate staffing deficits within the organisation and not impact on the care being provided to the young people. The centre manager must ensure that accurately records are kept of who works in the centre and of any changes that occur.

A few arrangements were in place that promoted staff retention. These included training and continuous professional development opportunities, pension and health insurance options, and staff having access to a formal employee assistance programme.

The inspectors found deficits in safe recruitment from their review of a sample of staff personnel files. These related to reference verifications not being completed, gaps in training, one staff member's qualification not on file, lack of a CV for another staff member which prevented the inspectors from verifying their past experiences including social care and their most recent employment. The director of social care

must ensure that safe recruitment practices are always implemented and that deficits addressed in this report are rectified immediately.

Information relating to the centres support system for social care workers was contained in the 'guidelines for on-call' policy. In interview, staff and management described the system in place and referred to a tiered level traffic light system. In practice, social care leaders within the organisation shared tier one and were part of the 10 weeks on call rota at evenings and weekends. Tier two included back-up on-call centre managers and deputy centre manager with the director of social care named as tier three. Updates on young people in the various centres was done verbally between social care leaders. The policy lacked specific detail on how the policy was implemented as described above, there was no formalised procedure for recording decisions, how they are followed up including if concerns arose about staff practice. The director of care must ensure that procedures for on-call arrangements are detailed in the guiding policy and that formal records are kept to ensure that staff are delivering safe care practices.

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The director of social care must ensure that there are effective organisational workforce planning mechanisms in place that prevents the movement of staff from the centre to facilitate staffing deficits within the organisation and not impact on the care being provided to the young people.
- The director of care must undertake a review of the movement of staff related complaints, both informal and formal and the centres complaints policy to ensure that transparent, accountable and safe care practices are in place.
- The centre manager must ensure that accurately records are kept of who works in the centre and of any changes that occur.

- The director of social care must ensure that safe recruitment practices are always implemented and that deficits addressed in this report are rectified immediately.
- The director of care must ensure that procedures for on-call arrangements are detailed in the guiding policy and that formal records are kept to ensure that staff are delivering safe care practices.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	None identified.		
5	The registered provider must demonstrate their accountability in ensuring that a stable centre management structure is maintained in the centre that assures consistent leadership, governance and management will be provided to the staff team.	The registered provider will complete supervision with the centre manager every 4-6 weeks, on the standing agenda of supervision it will include the internal management team, staff retention and leadership within the centre. The registered provider will conduct an internal review on staff retention. The internal review will be completed by 30.11.2021. Learning identified from the internal review will be completed without delay.	Yearly appraisals will take place with the centre manager to ensure a high standard of leadership, governance and management is being provided within the centre.
	The centre manager must strengthen their leadership and management role in the centre including record keeping practices that address the deficits outlined in the report.	The centre manager will ensure the record keeping is improved in relation to review of daily logs and handover in relation to staff recording, ensuring the team meeting minutes accurately reflect discussions that have taken place and roster's being kept up	The centre manager will conduct regular in-house quality assurance audits in relation to the noted areas. These will commence in November 2021. Any deficits noted during the audit will be addressed without delay with the staff team by the

		to date with any changes that have taken place. This is effective immediately.	centre. The audit will be sent to the director of social care for review and input.
	The director of social care must ensure the continuation of external auditing arrangements in the centre.	The director of social care will ensure the continuation of external auditing arrangement in the centre. The next audit will be completed by 30.11.21. Any deficits noted during the audit will have an action plan developed, this will note the person responsible and the timeframe for actions to be completed.	All actions identified in the audits will be overseen by the director of social care to ensure completion. In addition, the director of social care will ensure that internal audits take place on an ongoing basis, these will take place quarterly.
	Centre management must develop a risk register to include risk assessment review processes to support the ongoing identification, assessment and management of risk.	Centre and organisational registers will be developed by the 30.11.21. These will be finalised with all centre manages within the December management meeting.	Centre management and line management, including the director of social care and registered provider will ensure that the organisational and centre risk registers are reviewed monthly or sooner as required once in effect in the external management meetings. This document will remain live.
6	The director of social care must ensure that there are effective organisational workforce planning mechanisms in place that prevents the movement of staff from the centre to facilitate staffing deficits within the organisation	The director of social care will conduct an internal review on workforce planning specifically in relation to movement of staff between centres. The internal review will be completed by 30.11.2021. Learning identified from the internal review will be	All actions identified in the internal review will be completed. In addition, the director of social care will ensure that internal reviews take place in line with our internal review policy.

	and not impact on the care being provided to the young people.	actioned for completion as soon as possible.	
	The director of care must undertake a review of the movement of staff related complaints, both informal and formal and the centres complaints policy to ensure that transparent, accountable and safe care practices are in place.	The director of social care reviewed the young person's complaint in relation to the movement of staff a month after the complaint was made. No more issues arising. Complaints in relation to the movement of staff by young people will be investigated by the external social work departments.	A review of the complaints policy will take place by the director of social care, registered provider and regional manager and centre managers in the policy review group. This will be completed by the 30.11.21.
	The centre manager must ensure that accurately records are kept of who works in the centre and of any changes that occur.	The centre manager has implemented a new format for recording roster changes that occur. This is in place from 01.11.2021. This will be updated on daily basis as required.	The centre manager will review the roster monthly to ensure all updates have been completed. The roster will be stored in the management files and line management will review rosters during quality assurance audits.
	The director of social care must ensure that safe recruitment practices are always implemented and that deficits addressed in this report are rectified immediately.	The director of social care will review the recruitment policy in relation to the points noted. This will be completed by 15.12.21 and update's will be implemented without delay.	The administrative worker will follow the updated policy. The director of social care will ensure the audits are completed on the staff files to ensure ongoing compliance.

	The director of care must ensure that procedures for on-call arrangements are detailed in the guiding policy and that formal records are kept to ensure that staff are delivering safe care practices.	The director of social care will review the on-call policy. This will be completed by 15.12.21. A formal record has been developed and will be implemented by the 30.11.21.	The updated on-call policy and formal record will be reviewed by the director of social care to ensure it is effectiveness on an ongoing basis.