An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 171

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Terraglen Residential Care Services Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**07th & 08th February 2023**
Registration Status:	**Registered from 17th April 2023 to the 17th April 2026**
Inspection Team:	**Sinead Tierney** **Anne McEvoy**
Date Report Issued:	**4th May 2023**

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 the centre with the standards and regulations and the operation of the centre in line with its registration. The centre was first registered in April 2020. 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 as a dual occupancy centre for young people aged thirteen to seventeen years on admission, on a medium to long term basis. The statement of purpose described a relationship-based approach to delivery of care drawing on 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	3.1, 3.2
4: Health, Wellbeing and Development	4.2
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 via teleconference 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 30th March 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 13th of April and a subsequent CAPA on the 18th of April 2023. The CAPA was reviewed and all non-compliance with regulatory matters identified in the report have now been addressed to the satisfaction of the Alternative Care Inspection and Monitoring Service and the relevant regulations now deemed to be met.

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: 171 without attached conditions from the 17th April 2023 to the 17th April 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational 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 inspection highlighted that a child-centred approach that recognized the young people's rights, including their right to be listened to and participate in decision was in place. This was supported by policies. An open culture was evident whereby young people, and their families were encouraged to provide feedback and raise any issues. A booklet was in place for young people that outlined their rights, responsibilities, and external support services such as Empowering Young People in Care (EPIC) and the Ombudsman for Children. Prior to one young person moving to the centre, the team went through the booklet, showed them pictures of the house and provided opportunities and time for questions to be asked. Tusla's *Tell Us* Complaints and Feedback Procedure was not included in the booklet and was not discussed with young people as part of individual work records reviewed.

One young person who met with inspectors stated they felt comfortable complaining and could do so to any member of the team. They discussed a complaint they had made and were satisfied with how it was dealt with and that no adverse consequences would happen as a result of complaining. Weekly young people's meetings were consistently held, and feedback discussed at team meetings. There was an established practice of inviting young people to read and comment on their daily logs.

The centre had a complaints policy that outlined informal and formal complaint procedures. Complaints training had been carried out by the director of operations in 2022. A review of records showed that complaints had been made by both young people and their families. All bar one of these complaints were closed. The records were detailed and outlined the steps undertaken by the social care workers and the manager. However, one aspect of the process was not clearly understood by staff and managers. There were various levels of understanding as to what determined if a complaint was upheld or not upheld with all interviewees providing differing definitions.

A family member of one young person was interviewed by inspectors. They spoke positively of how the young person was cared for by the team. They had previously complained about the young person looking 'shabby' in appearance and stated that whilst the team had provided an explanation for this, it remained a current concern of theirs. Their ongoing concern was relayed to the allocated social worker by inspectors. Social workers interviewed felt that the team promoted the voice of the young people and were good advocates.

Complaints featured on the agenda for each managers meeting, and the director of operations had carried out an audit against Theme 1 of the National Standards for Children's Residential Centres, 2018 (HIQA) in February 2022. The audit highlighted areas of good practice and areas for growth. Inspectors found that whilst actions from the audit were completed, the improvements were not sustained over the year and therefore did not indicate a culture of continuous improvement. This was a similar finding in audits completed under theme 3 and theme 4 and are highlighted in this report.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
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 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must update the young person's booklet to include information on Tusla's *Tell Us* Complaints and Feedback Procedure and share this information with young people.
- The director of services must ensure that all team members understand and can explain how a decision to uphold or not uphold a complaint is made.
- The director of services must ensure that improvements identified through the auditing system are embedded into practice.

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.

This standard was incorporated into the inspection due to the team's understanding and practice regarding child safeguarding. The centre manager was the designated liaison person however had not attended training relevant to the role. From interviews with team members and management, as well as a review of child protection and welfare notification forms (CPWRF's) submitted for both young people, inspectors found that the team and management did not have a sound understanding of the Children First Act, 2015 or Children First National Guidance for the Protection and Welfare of Children, 2017.

Whilst the inspectors acknowledge the legal duty of mandated people to report their concerns of abuse as outlined in the legislation, the team were reporting behaviours that one young person was engaged as child protection concerns. For example, one young person reported drug use and criminal behaviour, and this was reported via CPWRFs. A review of their care record showed that eleven CPWRFs had been submitted over a four-week period. All were relevant to behaviours of concern that did not involve a third-party causing harm. When asked in interview the reasons for reporting one incident where a substance was found in a young person's bedroom that was possibly drugs, a team member stated a CPWRF was submitted as it was against policy to allow drugs in the centre. Unnecessary details were also inputted into the forms relating to other young people who were not at risk of harm or abuse. During interview the allocated social worker stated that they had identified the majority of behaviours of concern were being reported as child protection concerns. They further stated that all CPWRFs related to those behaviours of concern were closed as they did not meet the threshold as defined. The register of CPWRFs held in the centre did not reflect the statement from the social worker.

Separately, a CPWRF was submitted following a young person who was nearing 18 years of age consuming a non-alcoholic drink whilst with family members. The actions of some adult family members were also outlined in the CPWRF. One member of the family subsequently made a complaint regarding the CPWRF being

submitted and on review of the complaint record by inspectors it was noted that the social care worker had no concerns regarding their behaviour.

A review of management meeting minutes evidenced that child safeguarding and CPWRF's were routinely discussed, however, the meeting in January 2023 noted that CPWRF's had become tick the box exercises. An audit in January 2023 found that it was not clear from a review of CPWRF's what the concerns were.

Based on the above, the inspectors found that the team and management did not understand Children First and the oversight mechanisms in place to ensure adherence were not robust.

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

The centre had a number of policies and procedures in place to support young people's needs and the management of their behaviour. Practice was supported by the centre's model of care and a behaviour management system.

All care team members held a valid certificate in the centre's behaviour management system. Additional training had been undertaken relevant to the needs of the young people. Staff were knowledgeable in interview regarding the vulnerabilities of young people and the supports required to respond to behaviours that challenge.

A range of planning documents were in place, including behaviour support management plans (BSMPs), individual crisis support plans (ICSPs), absence management plans and risk assessment to support young people. However, inspectors found, as did an internal audit in January 2023, that none of these documents were up to date. Given the behaviours of concern for both young people, this was not satisfactory. One rationale provided to inspectors was the impact due to insufficient staffing numbers. However, a review of team meeting minutes did not evidence discussion or accountability that the plans were not up to date or identity control measures to mitigate any impact due to staffing numbers. As noted previously, a review of audits identified that improvement actions were either incomplete or not implemented over a sustained period of time.

A sample of significant events were reviewed, and inspectors found examples of good practice, whereby the team utilised their relationships with young people and adhered to interventions laid out in plans. One young person told inspectors they felt supported with their needs and was able to reflect a recent significant event in their

life. Individual work records and attempts at life space interviews were on file for both young people to support them in developing an understanding of their own behaviours and needs. Social workers and a family member of one young person interviewed felt the team understood the needs of the young people, were responsive and caring in their approaches and notified them in a timely manner of any significant events. There was a strong focus on driving a multi-agency response for one young person with minutes kept of all meetings.

Although significant events were reviewed, records noted a general overview of behaviours of concern and did not examine any particular SEN or patterns. Reviews did not consider the key planning documents as previously mentioned and did not identify any key learning. A risk management system was in place however it was clear from audits that the director of operations provided significant guidance in terms of the system. Ownership of risk management was not evident at team level, as was demonstrated in a series of significant events that happened prior to inspection whereby no risk management plans were activated.

The centre had a register of restrictive practices however one young person had no permitted unsupervised free time. Given their age, there were no records on the care file of this restrictive practice and its review. There was limited use of consequences, however inspectors found that the ongoing use of a standard consequence in response in a young person missing from care was not effective and was being inconsistently applied by team members.

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 ,3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The registered provider must ensure that all team members fully understand Children First legislation and Children First National Guidance for the Protection and Welfare of Children, 2017.
- The registered provider must ensure that incidents are properly assessed to determine if they meet the threshold for reporting under Children First and effective oversight is in place.
- The registered provider must ensure that training is provided to those holding the position of designated and deputy designated liaison person.
- The centre manager must ensure that all planning documents to support young people are up to date.
- The director of services must ensure that significant events are effectively reviewed for learning purposes and in line with the centre's policy.
- The director of operations and centre manager must ensure that the risk management framework is understood and applied by all team members.
- The centre manager must ensure that all restrictive practices are appropriately assessed, reviewed and recorded.

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.

One young person had an up-to-date care plan on file that outlined their physical and mental health needs. The centre's escalation policy had been utilized due to delays in receiving the second young person's care plan. The director of operations informed inspectors that this had been received on the final day of inspection and was now on file. Aside from this the care records contained relevant medical histories.

Both young people had a general practitioner and ongoing efforts were evident to support young people to engage with specialist supports and assessments. Social workers and a family member interviewed stated the team were proactive in meeting the health needs of the young people. The team had availed of supports to guide them in their interventions in meeting the mental health needs of the young people. There was evidence of individual work with young people in relation to exercise, diet and routines and managing specific mental health needs. The team had completed self-injury and ligature training, however the ligature cutter was behind two locked

cabinets and not easily accessible in the event it was required. On discussion with the centre manager, they agreed to move it to a more accessible place without delay.

Placement plans allowed for planning on health however inspectors found current plans lacked defined health goals. An internal audit of theme 4 in August 2022 emphasised that the plans should have a continuous focus on health given the presenting needs of the young people. This was not evident from the current plans. One young person who was nearly 18 years of age had no goal identified in their plan to progress towards self-administering their medication. Their social worker confirmed in interview that this conversation had commenced however actions were not identified in plans.

A medicine management policy was in place supported by training that team members had undertaken. Medication was securely locked away and a review of handover records and staff practice evidenced that tasks in relation to medicine management were adhered to daily and weekly. There had been medication errors in recent months and an error audit system was in place in response to these events. A review of the audit found that whilst it outlined actions to minimize the likelihood of the error re-occurring, it did not address or document why the error occurred. The director of operations had identified this deficit on receipt of the audit from the centre manager however the record had not been updated to reflect this feedback.

Overall, with the expectation of goals within the placement plan, inspectors found the centre in conjunction with the social work departments were supporting the young people with their identified developmental needs.

Compliance with Regulation	
Regulation met	**Regulation 10**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must ensure that placement plans clearly reflect goals in relation to identified health needs.
- The centre manager must ensure the audits completed following medication errors are robust in assessing the full circumstances related to the incident.

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.

Significant changes within the senior leadership of the organisation occurred in 2022. The director of services and director of quality had resigned, and the director of operations was finishing in their role in February 2023. The registered provider had appointed a new director of services in January 2023 and was not replacing the director of quality post.

The centre also experienced a turn-over of staff, with three team members leaving in 2022 and a further two leaving during the inspection process. A review of management meeting minutes between September to January noted the staffing deficits within the centre however limited recruitment action plans were recorded from these discussions.

During the period September – December 2022, the centre had seven team members available. With further resignations in 2023, the centre had six staff at the time of inspection. Aside from the centre managers, the team comprised of one social care leader and five social care workers. There was one relief team member. Another team member was due to commence extended leave in April meaning a further reduction in the near future. A review of rosters evidenced that two sleep over staff were rostered daily and on occasion, management, staff from outside the centre and agency staff were rostered to provide care for the young people. This resulted in young people experiencing a lack of consistency in terms of team members available to them. The impact of planning for young people was also noted previously in this report.

Consequently, the inspectors found that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The registered provider should ensure that there are sufficient numbers of staff in the centre having regard to the number of children residing there and the nature of their needs.

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 update the young person's booklet to include information on Tusla's *Tell Us* Complaints and Feedback Procedure and share this information with young people.	Young person booklet has been updated with Tulsa's Tell complaints and feedback and has been shared with young people through keyworking.	The centre manager will ensure to review the booklet and input any new information that is available for the young people as it occurs.
	The director of services must ensure that all team members understand and can explain how a decision to uphold or not uphold a complaint is made.	Additional training will be provided to the team to ensure full understanding of the complaints policy, the process and the outcome and reasons for same. Training will be delivered by acting director of services on the 03rd of May 2023.	The centre manager will ensure all new staff receive training regarding the complaints policy/process, and check and challenges will occur during team meetings and supervisions.
	The director of services must ensure that improvements identified through the auditing system are embedded into practice.	The director of operations will complete an on-spot inspection every second month to ensure all recommendations from previous audits are followed and embedded into practice.	The director of operations will complete regular on spot inspections following audits to ensure all recommendations from themed audits are actioned on and evidenced in practice.

3	The registered provider must ensure that all team members fully understand Children First legislation and Children First National Guidance for the Protection and Welfare of Children, 2017.	The staff team will be scheduled for a refreshers training on children's first and child protection to ensure that all staff members fully understand the legislation. Training will be delivered by internal trainer on the 19th of May 2023.	The centre manager and senior management will ensure all staff complete the training during induction, and check and challenges will be completed in supervisions, team meetings etc to ensure all staff can evidence their understanding in a confident manner.
	The registered provider must ensure that incidents are properly assessed to determine if they meet the threshold for reporting under Children First and effective oversight is in place.	This was discussed further in senior management meetings following the inspection as regards the threshold for reporting CPWRF's to ensure all managers were aware of how to determine what meets the threshold as there was confusion as some CPWRF's were directed by senior management previously due to the risks the young people posed to themselves.	Refresher child protection training will be scheduled for all staff that require same. Senior management will also ensure there is clear and effective oversight of all incidents.
	The registered provider must ensure that training is provided to those holding the position of designated and deputy designated liaison person.	Training for designated liaison person has been sourced and booked for Monday 8th and Tuesday 9th May 2023.	The registered provider will ensure that the training for designated liaison persons will be sourced for all staff that require same for going forward.

	The centre manager must ensure that all planning documents to support young people are up to date.	Placement planning overviews were completed following inspection and are now in place for both young people and up to date .	The centre manager will ensure all relevant documentation for all YP is completed in a timely manner and inputted into their files.
	The director of services must ensure that significant events are effectively reviewed for learning purposes and in line with the centre's policy.	The director of operations discussed SENs in the SERG review with the team and discussed follow ups and recommendations to ensure learning for the team.	All SENs are reviewed by the director of operations and follow ups and recommendations are fed back to the teams, senior management and DoS. These will then be reviewed in audits to ensure all recommendations are followed up on.
	The director of operations and centre manager must ensure that the risk management framework is understood and applied by all team members.	Risk assessment training will be provided to the team to refresh their knowledge on the risk management framework to ensure they understand same. Training will be delivered by internal trainer on the 16th of May 2023.	The centre manager will ensure to bring all new risk assessments into the team meetings to ensure they are evaluated, reviewed and discussed in detail. This will ensure the team understand the process of same.
	The centre manager must ensure that all restrictive practices are appropriately assessed, reviewed and recorded.	The centre manager completed a full review of all risk assessments in place in the centre to re-evaluate and record same. This was also discussed in the team meeting following.	The centre manager will ensure to complete a full audit of all risk assessments in place on a more regular basis, including restrictive practices. This will ensure they are reviewed and assessed on a continued basis.

4	The centre manager must ensure that placement plans clearly reflect goals in relation to identified health needs. The centre manager must ensure the audits completed following medication errors are robust in assessing the full circumstances related to the incident.	Goals in relation to identified health needs have been added to placement plan overview and placement plans. The centre manager completed a medication audit following and discussed the errors that occurred to the team, and the circumstances relating to same to try prevent this from reoccurring.	The centre manager will complete keyworking meetings with the keyworking team to ensure all relevant goals in relation to the young people's identified needs are inputted into the forward plans. The centre manager will ensure there is a full oversight of all audits completed in the centre and appropriate and effective follow ups are completed to be able to identify the errors and reasons for same. These will then be discussed in team meetings for learning.
6	The registered provider should ensure that there are sufficient numbers of staff in the centre having regard to the number of children residing there and the nature of their needs.	The register provider and director of operations have been spending significant time in recruitment and the retention of staff. Interviews have been scheduled and posts have been offered. There will continue to be explorative meetings to help in the retention of incoming staff.	The organisation will continue to place adverts nationally, continued recruitment, research benefits that can be sourced that will help in the retention of incoming staff. All to ensure the centres have the required staffing for the young people in their care.