An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 018

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Kellsgrange Residential Services Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced themed**
Date of inspection:	**05th, 06th & 07th January 2022**
Registration Status:	**Registered from 11th April 2021 to 11th April 2024**
Inspection Team:	**Joanne Cogley** **Paschal McMahon**
Date Report Issued:	**1st March 2022**

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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 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 the centre with the standards and regulations and the operation of the centre in line with its registration. The centre was first registered in 2015. At the time of this inspection the centre was in its third registration and in year one of the cycle. The centre was registered without attached conditions from the 11th of April 2021 to the 11th of April 2024.

The centre was registered as a multi occupancy centre to accommodate four young people of both genders from age thirteen to seventeen on admission. Their model of care was described as a relationship-based model which is trauma informed. The model is underpinned by a theoretical approach across five core themes: food and mealtimes, the home environment, the language in use, boundaries and relationships. At the time of inspection there were four young people residing in the centre.

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 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 on the 27th January 2022 and to the relevant social work departments on the 27th January 2022. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 16th February 2022. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 018 without attached conditions from the 11th of April 2021 to the 11th of April 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

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.

At the time of inspection there were four young people living in the centre. Two of these young people had an up-to-date care plan on file, while the care plans for the other two young people related to their previous placements. Of these two, one young person was admitted early in September 2021; however their statutory review did not occur until late December 2021. The second young person was admitted in November 2021 and their review was not scheduled to occur until February 2022 – both of which were outside the required statutory timeframe for young people placed in residential care. There was evidence on file to show that the centre manager continued to make attempts to ensure these review meetings occurred as a matter of priority. There was evidence that the other two young people in placement had been encouraged to attend their care plan review meetings and where they chose not to, had completed the "*me and my care plan*" document and this was discussed in detail at the meeting. Parents were invited to attend these meetings but in some cases they chose not to attend.

All young people in placement had up to date placement plans on file. The placement plans for the two young people without up-to-date care plans were based on referral information and known information to the staff team. There were clear tangible goals and there was evidence that the young people had input into the development of goals. Placement plans were drawn up for a three month period, prepared by keyworkers and reviewed by management in case management meetings, team meetings and supervision. Social workers interviewed stated they were satisfied that the placement plans were reflective of the needs of the young people.

Inspectors reviewed a sample of key work records and found these to be detailed and in line with the goals of the placement plans. There was evidence of resources being used such as sex education programmes, recognising emotions and substance misuse programmes. Key work planning meetings occurred on a monthly basis with the keyworker, a member of management and the organisation's psychotherapist. A plan was developed for the month ahead for areas of focus and delegated to team

members. Inspectors reviewed minutes of these meetings and found that while they were clear and detailed, different templates and formats were being utilised by different keyworkers and inspectors recommend that one consistent template is utilised for the purpose of recording these meetings.

Inspectors reviewed a number of records and found evidence of young people being supported and facilitated to access external supports and specialist services in line with their care plan. There was evidence of engagement with CAMHS, occupational therapy, equine therapy and juvenile liaison officers. The organisation also employed a psychotherapist. There was evidence of the psychotherapist working both with the young people and with the staff team to guide and support work being completed in placement. One social worker noted that despite their allocated young person refusing to engage in services, the centre had provided all opportunities and completed individual work with the young person around the importance of engaging in supports.

From a review of communication records inspectors noted there was regular telephone and email contact between the centre and relevant professionals. There were two young people in placement who did not have assigned social workers at the time of inspection. There was evidence in both cases that social work team leaders were available to support placements. Social workers interviewed confirmed they received regular updates from the centre manager, who was flexible to working with the needs of the young people.

Compliance with Regulation	
Regulation met	**Regulation 5**
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 required

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.

Inspectors found evidence of good leadership in the centre. The staff team interviewed stated the manager led and supported the team on a daily basis. There was evidence that the centre manager was attending team meetings, key work meetings, professional meetings and offering guidance and support to the staff team. At the time of inspection, the centre manager was completing a masters degree and the staff team highlighted that they believed this was of benefit to them as the manager was incorporating their learnings into team meetings and supervisions to foster a culture of learning within the centre. The centre manager was clearly identified as the person in charge with overall executive accountability, responsibility and authority for the delivery of service. When they were absent from the centre the deputy manager would assume responsibility and accountability.

The centre had a management structure in place that consisted of a centre manager, deputy manager and three social care leaders. All members of the management team were appropriately qualified and experienced. Inspectors saw evidence of a delegation log in place for all members of management with evidence of follow up and outcomes being recorded. Members of the management team also partook in an on-call rota. Those interviewed reported this was an effective system for providing guidance and support to the staff team where required. Additional support could be provided to those performing on call duties by the director of services.

The organisation had a number of auditing systems in place to allow for oversight and governance. Internal audits were conducted by the centre managers and staff using a number of self-assessment tools. These audits were then forwarded to the director for review along with the manager's weekly and monthly reports. The director informed inspectors that they would review and comment on these audits and discuss any issues that arose with the centre manager. The director stated they had a trusting relationship with the centre manager thus accepting their findings in audits without needing to validate information but could request further information

from the centre manager if required. In addition, the director conducted their own audits of the centre. The two most recent audits took place in June and September 2021 and covered a three month period. The audit carried out in June reviewed complaints and significant event notifications while the audit in September reviewed health and safety. Inspectors found from reviewing both the internal and director audits that a number of follow up actions were identified. However, it was unclear to inspectors as to whether these recommended actions had been completed as there were no clear action plans evident in response to actions identified in these audits. Inspectors also noted that in the manager's monthly audits there were a number of items copied and pasted month on month with no evidence of actions being carried out. For example, July, August and September recorded the same response to maintenance issues. There was no evidence to demonstrate these had been acted upon. The registered provider must ensure that the auditing process is more robust by ensuring that all audits contain clear action plans identifying actions required, the person responsible, timeframe and date of completion. This process should also include a mechanism for the validation of information received by the director from the centre manager in their weekly and monthly reports and internal audits.

The director of services confirmed to inspectors that there was a service level agreement in place with the national private placement team and that they provided regular reports to them updating them on all aspects of the service being provided.

The organisation's policies and procedures had been reviewed and updated in September 2021 and inspectors were informed that a training date for staff was scheduled in January 2022. Inspectors reviewed a sample of these polices during the course of the inspection and were satisfied that they were in compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). Staff members interviewed were aware of the centre's safeguarding policies including reporting disclosures, whistleblowing and covid-19 protocol.

There was evidence of a risk management framework in place however it did not appear to be applied consistently across a review of care files. The risk management policy clearly identified that risk would be rated on a scale of 1-5 likelihood vs probability. There were a number of different matrix systems being used (numerical as per policy, high-med-low rating and colour coded systems). There were different applications across each risk register. Not all staff in interview had a clear understanding of the risk matrix system, also the director of services was not clear on what matrix was being utilised in the centre and had identified it as an area for further development. The centre risk register appeared to focus mainly on

environmental risks such as the open fire, cleaning products and infection control. It did not account for a number of risks identified during the inspection process such as positive covid cases / staff shortages due to testing and isolation rules, the physical element of the centre's behaviour management model training having expired and previous inspections findings re: premises and safety. The director of services and centre manager must ensure the risk management framework is being applied consistently within the centre and that all staff members are confident in identifying and assessing risk daily.

The centre had an individual absence management plan on file for each young person which detailed the centre's response and actions to be taken should the young person be reported missing from care. The template used by the centre did not include all of the information required in the HSE / Gardai Missing Child from Care Report Form. The template did not record the young person's curfew time and individuals that should be contacted if the young person goes missing and needs to be amended to include these details.

The centre had measures in place for the management of the Covid 19 virus and inspectors were told that there had been no outbreaks in the centre. Staff informed inspectors that the centre had adequate supplies of anti-bacterial products, hygiene equipment, and personal protective equipment and staff were undergoing regular antigen testing. There was evidence that the risks associated with Covid 19 were reviewed on a regular basis at 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	**5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the auditing process is more robust by ensuring that all audits contain clear action plans identifying actions required, the person responsible, timeframe and date of completion. This process should also include a mechanism for the validation of information received by the director from the centre manager in their weekly and monthly reports and internal audits.
- The director of services and centre manager must ensure the risk management framework is being applied consistently within the centre and that all staff members are confident in identifying and assessing risk daily.
- The centre manager must ensure that the individual absence management plans are reviewed to include all relevant areas as highlighted in the HSE / An Garda Siochana missing child from care protocol.

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.

At the time of inspection the staff team within the centre consisted of a centre manager, deputy manager, three social care leaders, six full time social care workers and one part time social care worker. All staff members were qualified in social care and there was a balance of experience within the team. There was evidence of workforce planning through management meetings and roster planning. This took into account the manager's educational studies at the time of inspection and ensured there were plans in place to allow for college attendance and study leave where required. The centre had four relief staff members available to them, all were qualified and had experience working in residential care. From a review of a sample of rotas the centre had adequate numbers of staff to meet the needs of the current young people in placement. The centre had three staff on daily, two of whom worked an overnight shift and one of whom worked a day shift.

Five staff members had left the centre since the last inspection in February 2021 however three of these were in the process of returning to the organisation and were engaged in the vetting process at the time of inspection, a fourth left for career advancement and the fifth for personal reasons. Exit interviews had been completed

where possible. The organisation had a number of initiatives in place to promote staff retention, this included access to GP services, access to the organisation's psychotherapist, gym and swim memberships and access to a pension scheme. There were formalised procedures for on call arrangements in place at evenings and weekends.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1**
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

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	No action required	N/A	N/A
5	The registered provider must ensure that the auditing process is more robust by ensuring that all audits contain clear action plans identifying actions required, the person responsible, timeframe and date of completion. This process should also include a mechanism for the validation of information received by the director from the centre manager in their weekly and monthly reports and internal audits.	Acknowledged. To be reviewed and updated in organisational managers meeting on February 15th 2022 to ensure all updates in relation to action plans and timescales are incorporated throughout the centre. This will be relevant to: Managers Weekly Reports, Managers Monthly Reports, Child Protection Audits, Safeguarding Audits, Health & Safety & Maintenance Audits and any further All reports will open with Actions from last report, and close with actions to be completed before next report. The validation of information received and completed will be undertaken during the Managing Directors Monthly visit to the Centre.	Director to continue to audit the centre monthly. Action plans to be updated and include a recorded authentication process to be employed on formal monthly visits. External auditing company to be employed three times yearly to audit the centre. Company to introduce internal Centre audits whereby one management team will audit another Centre, these audits will consider validation of actions on all audits and act as a streamlining mechanism for all units. The reviewed and updated documents to be sent to Inspection & Monitoring (if applicable) to show updates to auditing process. If required, disciplinary procedures if work is not being undertaken and provided

			consistently.
	The director of services and centre manager must ensure the risk management framework is being applied consistently within the centre and that all staff members are confident in identifying and assessing risk daily.	All Risk Management within the house has been reviewed and updated to ensure that the one Risk Matrix Framework is used throughout – Completed. Risk Management Refresher Training for the team. Scheduled for Tuesday, March 2nd. A review of current Assessment Brief of the staff team will be undertaken in Centre Managers Meeting on February 15th with any updates being completed by the next Centre Managers Meeting (March 15th) and document finalised. New assessments then to be completed by all staff who have completed training. Management Audits weekly and monthly through in-house auditing systems.	Risk Management refresher training to be held with the team to ensure all updates are formally discussed and skills of the team assessed. Training will be held in-house by Centre Manager, who is a qualified Trainer. External trainers to be requested to undertake an assessment with staff subsequent to training completed with them to assess the effectiveness of the instruction. Reinductions should focus on whether the training was successful. Outcomes can inform further action in regards the training area. There continues to be an emphasis on risk management discussion in both team and management meetings. Assessments and mentorship for all new staff through induction, re-induction and supervision to continue.

	The centre manager must ensure that the individual absence management plans are reviewed to include all relevant areas as highlighted in the HSE / An Garda Siochana missing child from care protocol.	Acknowledged. All young persons IAMP's have been updated to reflect the changes suggested. IAMP's sent to Social Workers for review and signing off on.	Risk Management Training to take place yearly, or when there are any updates to the Centre Policy on Risk Management. Ensure all new admissions going forward have the updated IAMP. Review of policy on IAMP and the updates made in team meetings.
6	No action required		