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: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Terraglen Care Ltd**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Announced**
Date of inspection:	**29th & 30th May 2024**
Registration Status:	**Registered from 26th September 2022 to the 26th September 2025**
Inspection Team:	**Ciara Nangle** **Janice Ryan**
Date Report Issued:	**27th September 2024**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 26th September 2019. At the time of this inspection the centre was in its second registration and was in year two of the cycle. The centre was registered without attached conditions from the 26th September 2022 to the 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. A derogation was in place for one of the young people due to their age being below the range of the centre's registered purpose.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2 & 2.3
4: Health, Wellbeing and Development	4.2

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 24th July 2024. 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 August 2024. 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 26th September 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
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 wellbeing and personal development.

One young person residing in the centre had an up-to-date care plan on file. This had been developed during the statutory child in care review that had occurred earlier in the month. The other young person also had a Child in Care Review during the same month however on the days of inspection, the care plan had not yet been provided to the centre. The social worker subsequently confirmed that this has been shared.

While a statutory review had occurred for both young people in the month the inspection occurred prior to this the child in care review meetings had not been occurring for either child in line with statutory requirements. As such up to date care plans had not been in place for the duration of the young people's placements in the centre. There was evidence on both young people's files of the centre requesting and advocating for these meetings to be convened and for a care plan to be provided. For one young person in particular this had been requested on multiple occasions and had been escalated to senior management, who in turn, had escalated this within the social work department. This had resulted in a review being convened in May 2024. The social work department advised inspectors that statutory reviews would continue to take place in line with statutory requirements.

Both young people had up to date placement plans which were aligned to the actions agreed within their statutory reviews. The placement plan had clear achievable goals that were being worked towards. Staff in interview were aware of the goals and the steps required to achieve these goals. Within the placement plan the views of the young person and their parent were included. Through key working the young people were helped to understand the goals of their plans. A copy of the placement

plan was shared with the social workers. One social worker advised that they were satisfied with the goals being worked towards and found the centre to be proactive in supporting the young person to achieve in all areas of their life.

Within staff team meetings there was discussion in relation to the placement plans and staff were provided opportunities to contribute to these within this forum. There was a key working plan developed for each young person aligned to the goals of their placement plans, which included a calendar of topics to be covered and identified particular staff to complete these.

There was a significant amount of key working being completed with the young people to support them around their identified needs. This work supported them working towards longer term goals. It was age appropriate, and both planned, and opportunity led. Records maintained of sessions completed were of a good quality and there was evidence of management oversight within these.

There was regular communication between the social workers for the young people and the centre. However, for one young person little progress was being made in terms of sourcing external supports, providing the requested documentation for the young person's care file and visits to the young person in the centre. This had resulted in the centre submitting a complaint. This is detailed further in the below sections. Communication had improved following on from this. For the other young person, the social work department were responsive to the centre and supported them in working towards the goals of the placement and care plans. However, visits to the centre by social workers were minimal.

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The centre was an appropriate size and layout for the provision of safe and effective care to the two young people currently living there. The centre had appropriate insurance in place. There was a visitors' book in operation, where visitors to the centre were required to sign in. On review of this, inspectors noted that not all visitors e.g. external maintenance contractors, were signing into this book and improvement is required to ensure that a safe environment for young people, staff and visitors is maintained.

The centre had an open plan kitchen, dining and sitting room area which provided a homely environment for the young people. There was a games room, which was

decorated in a child friendly way and had a number of recreational activities for the young people to engage in. There was also a shed converted to a home gym with some exercise machines available for the young people. This had been decorated by a previous resident and both young people reported within their key working sessions and one young person to inspectors, enjoying the use of this area.

Both young people had their own bedroom. It was evident from the discussions recorded within the young people's meeting minutes that they had been involved in the decorating of these rooms and they had adequate storage for their belongings. All bedrooms had a large lit fire exit sign above the door, and these were under review to try to minimise the interference of these lights on the young people's rooms. Some of the furniture within one of the young people's bedrooms required repair, however the centre was aware of this, and plans were in place to address it. The house had a large garden area surrounding it and this was well maintained and had outdoor recreational activities for the young people.

There was adequate bathroom facilitates for the young people and staff. One young person had their own ensuite bathroom and the other had access to a large bathroom directly across from their bedroom.

The centre's electrical equipment was scheduled to undergo PAT testing the week following inspection. This report was provided to inspectors and confirmed all appliances were in working order. Maintenance requirements within the centre were recorded in a variety of forums, including a maintenance log, health and safety audits and team meeting records. At times it was hard to track when issues were identified to be repaired as there was no consistent recording mechanism in place. When items were recorded within the maintenance log, they included the date of completion and were signed off, however at times they were only recorded in the monthly health and safety audit, or featured as a discussion in team meetings and as such dates relating to the issue were not available. A consistent mechanism for recording, logging and escalating maintenance tasks is required to ensure they are completed and to allow for management oversight on the issues.

The centre was clean and adequately heated on the day of inspection. There was a detailed cleaning schedule in place within the centre. Additional cleaning measures had been implemented due to the needs of one young person within the centre to ensure the health and safety of both staff and residents. The staff interviewed were clear on the additional measures in place and these were regularly discussed in team meetings, handovers and other relevant forums.

The centre complied with the requirements of fire safety legislation, building regulations and health and safety legislation. The centre maintained a fire register which included dates of service checks to the fire safety systems in the centre. These service checks were in date and any identified issues were rectified by an approved fire service company.

Staff members had completed fire safety training and for the two members of the team who required it there was a plan in place to for this to be completed. There was an evacuation route on display within the staff office and the centre developed individualised fire escape plans for the young people in centre. Regular fire drills were undertaken as required both during daylight hours and in darkness. Firefighting equipment was at the designated fire points and was subject to annual service checks. Daily and weekly checks of the fire safety routes, system and equipment were undertaken by the staff team and documented issues identified. These were rectified in a timely manner and there was evidence of management oversight of these. Staff in interview were aware of the procedures in place around fire safety within the centre.

A number of fire doors within the centre were not self-closing and required repair to ensure this issue was rectified. The centre had already identified issues with some of the fire doors where more significant repair was required and the maintenance of these was in progress.

There was an up-to-date health and safety statement in place which outlined the roles and responsibilities of the organisation and employees in relation to health and safety. While this was an organisational statement, it identified the relevant persons within the centre with Fire Aid Responder training. It noted that all environmental risks were contained in the centre's risk register and directed staff to review these to promote their safety. This was reviewed recently in a team meeting and staff were in the process of signing this off to demonstrate that they had read the updated statement.

An environmental risk register was in place within the centre and recorded all environmental risks to staff, young people and visitors to the centre. On review of the environmental risk register for the centre, a number of environmental risks remained open for a number of years. While some of these risks remained active, they did not indicate dates of review and updated risk assessments were not on file. Other risks which were no longer present had not been closed off on the register. When a risk was open and active, the risk assessments in place and the controls put in place to mitigate the risk were appropriate to manage it. A review of the environmental risk

register is required to ensure that it only contains open risks, and that all associated risk assessments are up to date to ensure the controls in place reflect the current situation regarding the current residents, their ages and presenting needs.

Accidents were recorded within the accident register and if it was relating to a young person a copy was maintained on their care record. There had been no significant accidents involving the young people or staff team in the period under review.

The centre had access to two cars to facilitate the transport of the young people. These had appropriate tax and insurance. Regular checks were completed by the team on the cars and no issues were noted. There was evidence of management oversight on these checks. Driver licences for the relevant staff were held on their personnel files.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **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	**Standard 2.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that all fire doors are compliant with relevant fire legislation and are fully functional and advise ACIMS as soon as this is completed.
- The registered provider must ensure that there is an effective system in place for the recording, tracking and escalation of maintenance issues which clearly demonstrate the date the issue was identified and rectified.

- The registered provider must ensure that the environmental risk register only contains active risks that have up to date corresponding risk assessments in place that are reviewed on a regular basis.
- The registered provider must ensure that all visitors to the centre sign into the visitors book to ensure safe care within the centre.

Regulation 10: Health Care
Regulation 12: Provision of Food and Cooking Facilities

Theme 4: Health, Wellbeing and Development

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

Both young people in the centre had several additional needs which required external supports.

For one young person, at the time of their admission six months prior to this inspection, it had been identified that they required assessments from a variety of disciplines to inform their care plan and to guide the work that the team could undertake. While the inspectors saw evidence of the centre completing work with the young person to prepare them to attend basic appointments that the centre had arranged such as the doctor and dentist, the external specialist services remained outstanding. The centre had advocated with the social work team in relation to this however little progress was made which resulted in the centre management submitting a formal complaint on behalf of the young person due to the delayed access to the required services. In response to this complaint a plan was put in place for these services to be sourced within a specified time. However, these assessments had not yet commenced at the time of this inspection and in interview the centre manager advised that further follow up with the social work team would occur. The social work department advised inspectors that these assessments remained outstanding, but a plan would be put in place to commence these as soon as possible.

In relation to the other young person, additional support services were in place to meet their needs, however at times they refused to engage. There was one identified service required which was outstanding and the young person had been on a waiting list for this for several years. There was evidence of the centre proactively following

up with the service however an appointment had not yet been offered. Consideration to alternative options should be discussed given the identified need remaining unmet.

Some medical information was available on file for one of the young people and they had a valid in date medical card and were registered with a local General Practitioner (GP). There was evidence of them being brought to and supported in attending appointments with work in advance being completed. Neither young person had their immunisation history on file however there was evidence of the centre following this up with the social work department in relation to both young people.

The other young person's medical history had not been provided to the centre. Some documentation had been provided at the time of referral however further information remained outstanding. There was evidence of the centre requesting these documents on an on-going basis from the social work team, and requests for release forms to be signed off so that this information could be transferred to the local GP. This had also been requested by senior management to the equivalent level within the social work department however it remained outstanding at the time of this inspection. This young person was registered with the local GP and had a medial card in place.

There was a medication management policy in place within the centre and staff in interview demonstrated an awareness of this and the associated processes. Adherence to this policy was reflected within the documents for each young person relating to the administration and storage of medication within the centre including management oversight and sign off. One young person did not have a photograph as per the policy on their file, however this was due to their refusal and was noted on their care file. All staff were trained in the safe administration of medication. Regular medication audits were completed by the centre manager and no deficits had been identified.

Compliance with Regulation	
Regulation met	**Regulation 10** **Regulation 12**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 4.2**

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

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered provider must ensure that all fire doors are compliant with relevant fire legislation and are fully functional and advise ACIMS as soon as this is completed.	The centre was aware a number of the fire doors were not self-closing and had notified maintenance which were starting the repairs during inspection. Some have been completed and parts ordered for the remainder which is scheduled to be repaired when the scheduled maintenance returns from holidays week of 19th of August.	SCM will ensure regular checks will be completed in relation to fire safety and should issues arise within the centre regarding fire regulations, this will be recorded and highlighted, where the necessary maintenance will be completed in a timely manner.
	The registered provider must ensure that there is an effective system in place for the recording, tracking and escalation of maintenance issues which clearly demonstrate the date the issue was identified and rectified.	There has been a new maintenance register introduced by Director of Operations within the centre since the inspection occurred. This will ensure all maintenance is recorded and tracked in a timely manner.	SCM will ensure to have oversight on the maintenance in the centre, where all issues identified will be completed in a timely manner. If not completed, an explanation noted, or escalated to senior management.

	The registered provider must ensure that the environmental risk register only contains active risks that have up to date corresponding risk assessments in place that are reviewed on a regular basis. The registered provider must ensure that all visitors to the centre sign into the visitors book to ensure safe care within the centre.	Since the date of inspection all health and safety risk assessments have been reviewed and updated, where all risk assessments which are no longer relevant have been closed and ones which required updating have been updated. The risk assessment register has been completed in line with all relevant changes. On some occasions the visitor register did not correlate to the visitors to the centre. This has been discussed in team meetings following inspection to ensure this does not occur moving forward.	On the date of inspection, the risk register did not correlate with the review dates on the risk assessments on file, although they had been reviewed. SCM will ensure the registers are reviewed and monitored daily to ensure they are always up to date to reflect the review dates and outcomes. This has been discussed in team meetings to ensure all staff are aware the visitors book is to be utilised at all times. SCM will have oversight to ensure this is occurring. As part of the induction process all new staff will be informed of the importance of the visitor's book being completed.
4	None Identified		