

Health Information and Quality Authority Regulation Directorate

Monitoring Inspection Report on children's
statutory residential centres under the Child Care
Act, 1991



Type of centre:	Children's Residential Centre
Service Area:	CFA South CRC
Centre ID:	OSV-0004650
Type of inspection:	Unannounced Follow Up Inspection
Inspection ID	MON-0018200
Lead inspector:	Ruadhan Hogan
Support inspector (s):	Patricia Sheehan; Susan Geary; Rachel McCarthy

Children's Residential Centre

About monitoring of children's residential services

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

The Authority is authorised by the Minister for Children and Youth Affairs under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011, to inspect children's residential care services provided by the Child and Family Agency.

The Authority monitors the performance of the Child and Family Agency against the National Standards for Children's Residential Services and advises the Minister for Children and Youth Affairs and the Child and Family Agency. In order to promote quality and improve safety in the provision of children's residential centres, the Authority carries out inspections to:

- assess if the Child and Family Agency (the service provider) has all the elements in place to safeguard children
- seek assurances from service providers that they are safeguarding children by reducing serious risks
- provide service providers with the findings of inspections so that service providers develop action plans to implement safety and quality improvements
- inform the public and promote confidence through the publication of the Authority's findings.

Compliance with National Standards for Children's Residential Services

The inspection took place over the following dates and times:

From:	To:
06 December 2016 08:30	06 December 2016 18:00
07 December 2016 08:30	07 December 2016 16:00

During this inspection, inspectors made judgments against the *National Standards for Children's Residential Services*. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

The table below sets out the Standards that were inspected against on this inspection.

Standard	Judgment
Theme 1: Child - centred Services	
Standard 4: Children's Rights	Requires improvement
Theme 2: Safe & Effective Care	
Standard 5: Planning for Children and Young People	Requires improvement
Standard 6: Care of Young People	Significant risk identified
Standard 7: Safeguarding and Child Protection	Requires improvement
Standard 10: Premises and Safety	Requires improvement
Theme 4: Leadership, Governance & Management	
Standard 2: Management and Staffing	Requires improvement
Standard 3: Monitoring	Meets standard

Summary of Inspection findings

The centre was located on a large campus style facility which provided a range of services to young people and families. Three residential units provided care for up to 15 boys aged 12 to 16 years on admission. The centre was located on the outskirts of a large town. Additional facilities on campus included an on-site school, a two-bed roomed cottage which was used as an independent living facility for young people aged 16 years and over, a sports complex, administration buildings, and extensive grounds which were used for various activities, for example soccer pitches and horse stables. The centre had a facility to provide accommodation for family visits. The campus on which the centre was located also accommodated other Tusla services. At the time of the inspection, there were 9 children living in the centre.

During this inspection, inspectors met with or spoke to 3 children, managers and staff. Inspectors observed practices and reviewed documentation such as statutory care plans, child-in-care reviews, relevant registers, policies and procedures, children's files and staff files.

Inspectors also spoke with the Nurse Practitioner attached to the campus.

The centre was last inspected in August 2016 and this was a follow up to that inspection.

For the purposes of this inspection, inspectors reviewed the actions that Tusla committed to undertake following the inspection in August 2016. At that time, significant failings were found in relation to the care of young people, safeguarding, premises and safety and management and staffing. In total, improvements were required for seven standards.

The management team undertook implementation of a large number of tasks to improve service delivery in the centre following the last inspection in August 2016. Some progress has been made in relation to some of these tasks. For example, improvements had been made in the reporting of significant events and child protection concerns.

Inspectors found progress in others tasks has been slow. A comprehensive review of practice had not been conducted and the workforce was not receiving training in behaviour management. Improvements were not evident in how staff responded to children's risk taking behaviour. Staff expressed concerns that they didn't have the tools to manage behaviours. Four children had been engaged in risk behaviours similar to those behaviours found on the last inspection in August 2016. Following the inspection, these most recent concerns relating in particular to two young people, were escalated

to the centre management and a plan to respond to the needs of these two children was received.

In relation to the governance and management of the centre, there had been insufficient progress in a number of areas including supervision, team meetings and quality assurance. Overall inspectors were not confident that Tusla had made sufficient progress to ensure that deficits identified in relation to the culture of care and associated care practices in the centre, including management of behaviour, safeguarding, child protection and institutional practices were being addressed as a matter of urgency. The lack of timely progress was escalated to Tusla management. A comprehensive response was subsequently received from Tusla outlining the measures that would be taken to address the deficits. This outlined the establishment of an oversight group to co-ordinate the response to action plans and ensure progress was made. In addition, the scope of the work of an external consultant was expanded to include a full strategic review of the service. In the interim, no further admissions to the centre will take place until this work has been completed.

The actions published separately to this report outline the improvements that are required.

Inspection findings and judgments

Theme 1: Child - centred Services

Services for children are centred on the individual child and their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.

Standard 4: Children's Rights

The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.

Inspection Findings

At the time of the last inspection in August 2016, improvements were required in relation to:

- the practice of night time checks
- the recording and oversight of complaints.

At the time of this inspection, a new policy on night time checks had not yet been implemented. As a result the old policy was still in use. This stipulated that when children were first admitted, hourly night-time checks were completed for the first two weeks. Following this, night-time checks were to be carried out three times per night. Inspectors found that some children were being checked at night in line with this policy and a risk assessment had not been carried out. Some children were checked more regularly. While these children did have risk assessments, the assessments did not justify the decision to carry out extra night time checks. The Residential Manager was interviewed two weeks after the inspection fieldwork and said that this practice had subsequently ceased.

Inspectors reviewed complaints in the centre and found that they had been correctly classified. One complaint had been made by a child since the inspection in August 2016. It was in the process of being investigated. The log in the centre had been amended to include if children were satisfied with the outcome or not.

Judgment: Requires improvement

Theme 2: Safe & Effective Care

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs.

Standard 5: Planning for Children and Young People

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. This plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

Inspection Findings

At the time of the last inspection in August 2016, improvements were required in relation to:

- informing Social Workers of new admissions to the centre
- the quality of placement plans
- prioritising one on one and key worker sessions with children
- leaving care and aftercare plans for children.

Since the last inspection, there had been no new admissions to the centre.

The centre was in the process of implementing a new format to record the plans for children while in placement in the centre. Inspectors reviewed a number of the plans and found the format allowed for more comprehensive detail to be recorded with timelines and persons responsible. The information recorded for individual young people, while not all yet fully completed, was comprehensive and addressed some areas. However, key areas, such as how to manage behaviours that challenge for children in crisis were not yet evident on the plans.

Inspectors reviewed children's files and found that key worker sessions were being completed with children and recorded.

The children in the centre, who were eligible for an aftercare service, had allocated aftercare workers and aftercare plans were in progress.

Judgment: Requires improvement

Standard 6: Care of Young People

Staff relate to young people in an open, positive and respectful manner. Care practices take account of young people's individual needs and respect their social, cultural, religious and ethnic identity. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

Inspection Findings

At the time of the last inspection, there were significant deficits found with how the centre responded to children in crisis. The strategies in place were ineffective at preventing escalation in behaviours. Improvements were required in relation to:

- methods for managing behaviour for children with risk behaviours
- the quality and oversight of childrens individual crisis management plans (ICMP's)
- the effectiveness of absence management plans, key working and life space interviews when children returned following absconsions
- incorporating recommendations from Social Workers into childrens plans
- meal times in the centre.

In response to these findings, following the inspection in August 2016, Tusla committed to implementing a number of actions to address these deficits. These included:

- Engagement with an external independent consultant to reflect on principals and practices underpinning modern service provision. Since the last inspection two meetings had taken place and this focused primarily on leadership and management. Inspectors reviewed the terms of reference and minutes from these meetings. There was little evidence of planned engagement with staff to inform and direct their practice, particularly in relation to safeguarding and behaviour management practices. Inspectors found that progress was not timely.

- A review of the ratings systems, which formed part of their behaviour management practices, was to be completed. Since the last inspection, this review had not yet commenced.

- Individual Crisis Management Plans (ICMP's) were to be completed and reviewed by the centre manager, psychologist and staff team. Inspectors reviewed the key workers sessions, life space interviews and ICMP's when children returned to the centre following absconsions. The ICMP's had not been updated to capture the escalating behaviour of children. They did not show any new interventions being tried despite changes in circumstances and behaviours of children. Some ICMP's stated that there was nothing to preclude physical restraint being used where children had contra indicators listed to physical restraint. Progress has not been made since the last inspection. Where children were engaged in risk behaviour, the content of the key worker sessions was sometimes limited and did not evidence how behaviours that challenge were managed. There was also little evidence that life space interviews were used effectively to address behaviours with children.

- Team meetings were to be used to re-focus staff teams on the use of an approved model of crisis intervention, along with a model of promoting positive behaviour. However, inspectors reviewed and attended the team meetings and found that these models were discussed in brief and progress was slow.

- Inspectors found that the arrangements for meal times in the centre were largely the same as found on the last inspection with one significant change. While previously children were joined by others in the campus at meal times, at the time of this inspection, only staff who worked with children directly ate with them at meals times. The review of practice in relation to meal times had been commenced although was not completed.

Overall, progress was slow and inspectors were concerned at the lack of urgency to implement the actions outlined by Tusla. The centre management told inspectors that

the delivery of the action plan was paced in order to ensure real and meaningful change. In the absence of new or different approaches to responding to children in crisis, inspectors found the strategies used at the time of this inspection were not generally effective at preventing children from engaging in risk behaviour. This had not changed since the last inspection. In addition a comprehensive review of practice had not been conducted and the care staff continued to struggle to manage behaviour.

Inspectors found that a smaller number of children were found to be involved in challenging behaviour similar to the behaviour found at the last inspection. Since the last inspection in August 2016 until this follow up inspection, there had been 152 significant events. Children had absconded from the centre on 42 occasions and engaged in risk behaviours whilst outside of the centre on some of these occasions. Following the inspection, the issues in relation to two young people in particular were escalated to the centre management who provided a response to address these concerns.

Judgment: Significant risk identified

Standard 7: Safeguarding and Child Protection

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

Inspection Findings

At the time of the last inspection, the systems in place for safeguarding and child protection in the centre were not effective in keeping children safe from the risk of significant harm particularly during periods of crisis. Improvements were required in relation to ensuring that:

- safeguarding practices during periods of crisis were effective
- thresholds for child protection concerns were understood and the correct procedures for reporting child protection concerns were implemented
- child protection concerns were correctly classified
- staff in the centre had up-to-date child protection training
- a review of practices in the centre was undertaken
- arrangements were in place for the safe supervision of children when using the internet on their phones
- an increased awareness of whistleblowing and protected disclosure amongst staff

In response to these findings, following the inspection in August 2016, Tusla committed to implementing a number of actions to address these deficits. These included:

- A Child Protection Practice note was drafted following the last inspection and the Centre Child Protection Policy was amended to inform practice. Following the completion of training, the Practice Note and the amended Centre Child Protection Policy was implemented. Managers and staff in the centre had attended Children First training and additional training on the Child Protection Practice Note. This was reflected in training records. Therefore progress had been made in relation to this action.

- Inspectors found that each unit manager in the campus had been assigned the role of designated liaison person (DLP) since the last inspection. The DLP was responsible for reporting child protection concerns to the relevant social work department. Staff were clear on what they should report and who they should report it to. Centre management and staff were clear on how and to whom to report child protection concerns. Inspectors were assured that centre staff had a clearer understanding of thresholds for making a child protection referral.

- Inspectors were not assured that all practices throughout the centre were being independently reviewed to ensure they were safe. Inspectors were told that a review of practices had taken place at a management meeting. However, inspectors reviewed the minutes of this meeting and found that the review was limited to the practice of children visiting staff members homes.

- A review of Significant Event Notices (SEN's) for the crisis period was to be completed by a Principal Social Worker (PSW) from the local child protection team. At the time of the inspection, this review had not yet been completed. The review had commenced and was due for completion in January 2017.

- A policy on the safe use of mobile phones and social media was to be developed. Individualised assessment of children's access to phones at night was to be undertaken. At the time of this inspection, the policy on E-media was at draft stage and there was no evidence of assessments on the children's files.

Judgment: Requires improvement

Standard 10: Premises and Safety

The premises are suitable for the residential care of young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care (Placement of Children in Residential Care) Regulations, 1995.

Inspection Findings

At the time of the last inspection in August 2016, improvements were required in relation to:

- the layout of the centre which was unsuitable and contributed to children being placed at risk
- the institutional features of the campus
- the lack of a homely feel in the centre units
- ensuring all staff had up-to-date fire safety training
- medicines management practices

The action plan submitted to HIQA following the last inspection in August 2016 reported that the National Children's Residential Services would discuss and review the implications of the campus style setting on the provision of care and the future service development and direction. Inspectors were informed that process will focus on existing

institutional features, building layout and the use of the campus by other services. At the time of this inspection, this review had not yet begun.

Inspectors found there had been little changes to the layout of the campus. A senior manager said that as the campus was open, various measures were being considered to ensure it was safe. There was no evidence that systems had been put in place to verify who individuals were or redirect them when they came into the campus. Children told inspectors that people pass through the campus on the way to the river bank. Staff said they were concerned about the open campus and children having easy access to the river and town. At the time of inspection, there been a number of incidents that had occurred where children had absconded from the centre via the river bank into the town centre and became involved in at risk behaviour. While the frequency and number of these incidents was vastly reduced since the last inspection, inspectors were not assured of the suitability of the layout of the centre or that children could be kept safe within the campus.

- Inspectors visited each of the units in the centre. One unit had been decorated with pictures, rugs and house plants and had a much warmer and homely atmosphere than on the previous inspection. One unit had tattered sofas and there was little evidence of improvement. A senior manager told inspectors that new furniture had been ordered and plans were in place to redecorate. However, progress was not timely.

- Inspectors reviewed the fire training records and found that out of 37 care staff, 25 had completed up-to-date fire safety training. Therefore this action was partially completed.

- Medicines management practices in the centre required further improvement. A new policy and protocols had not been implemented at the time of inspection. The centre was also not yet using administration sheets to record medication and were still using the old system, which meant that there was a risk of an administration error. In the interim, the Unit Managers attended a two day training on medication management and there were plans for remaining staff to have training. The dates for this training had not yet been established.

Judgment: Requires improvement

Theme 4: Leadership, Governance & Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed. The system is subject to a rigorous quality assurance system and is well monitored.

Standard 2: Management and Staffing

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

Inspection Findings

At the time of the last inspection, there had been a failure to maintain effective management systems to ensure the service was safe. Deficits were found in the systems of monitoring, risk assessment, communication and supervision. Specifically, improvements were required in relation to:

- maintaining effective management systems to ensure the service was safe
- the notification of significant events as they were not consistently notified to persons external to the centre and senior managers were not aware of the risks in the centre
- accountability for decision making during team and management meetings
- the care managers log which did not show justifications for decisions and actions taken during incidents
- risk management, and issues of high risk, which were not escalated in a timely manner
- systems of auditing, monitoring and learning which were poorly implemented
- the poor quality of supervision of staff
- the lack of training for staff in core areas such as Children First, manual handling, first aid and Trust in Care.

In response to these findings, following the inspection in August 2016, Tusla committed to implementing a number of actions to address these deficits. These included:

-A two day workshop was facilitated by the Regional manager for the Resident Manager and Service Manager on roles, responsibilities and risk escalation. Inspectors interviewed all levels of management in the centre and found that following implementation of new systems, the roles and responsibilities of management were clear.

- An updated systems for quality assurance and oversight of significant event notices was to be put in place. At the time of this inspection there was an expectation by the Regional Manager that significant events would be read in real time by the Service Manager and responded to, to ensure risk behaviours did not escalate. There was also an expectation that the Resident Manager would read all SENs. The SENs were being notified to the relevant persons external to the centre and senior managers were being made aware of the risks in the centre. However, inspectors found there was a lack of urgency in responding to these risks. Inspectors did not see documentary evidence of the urgent response to these issues from senior management. The SENs relating to the children who were engaged in risk behaviour were reviewed at the time of this inspection. There was evidence of an escalation in behaviours over a number of weeks. Staff told inspectors they were concerned that the same risks remained that were present on the last inspection.

- Other measures for review of significant events included the establishment of the

National Significant Event Review Group (SENREG). One meeting had taken place since the last inspection and the minutes had not yet been written up. Given that this process was in its infancy, it was too early to comment on its effectiveness.

- Inspectors found that where there were issues of high risk, these had been appropriately escalated to the relevant persons. However, individual risk assessments had not been updated since the last inspection. Unit risk registers included risks such as exposure to criminal behaviour and alcohol and drug use. However, not all risks were included such as absconding.

- the establishment of a system of checks on centre documentation, including evidence of oversight by managers. Inspectors reviewed the documentation throughout the centre including SENs, daily logs and team minutes. There was evidence of oversight by the unit managers on some of this documentation which took the form of amending staff titles where necessary or initialising the file. However, there was little evidence of a review of the quality of the content including how staff responded to a particular incident. In addition there was little evidence of external oversight from the Service Manager.

- At the time of inspection, the care managers log was being reviewed.

- A new format for unit and management meetings was introduced to facilitate accountability since the last inspection. Unit meetings took place in each unit and were attended by staff and the unit manager. Inspectors observed one unit meeting and found it to be well organised with strong leadership. Management meetings were attended by managers across the campus. Inspectors reviewed the minutes from unit and management meetings and found that while the new format had been fully implemented at management meetings, it had not been implemented for unit meetings. This meant accountability on decision making was not transparent. In addition unit meetings were not taking place on a regular basis.

- At the time of this inspection, the service manager was in the process of completing an audit of supervision. Inspectors reviewed supervision records of staff and managers across each of the three units. The quality of recording of supervision was not consistent and was dependent on the supervisor. Inspectors found that some unit managers had comprehensive records of supervision detailing decisions taken with appropriate timeframes. However, other unit managers did not have the same quality recordings. The frequency of these sessions were outside the required timelines of four to six weeks. Supervision of the unit managers required improvement to ensure decisions were appropriately recorded with timeframes. Supervision of the residential manager also required improvement. The supervision record was handwritten and parts were not legible. There was little context given to justify a decision taken. As a result the reasons for some of the actions were not evident.

- Staff had up-to-date training in Children First. Up-to-date training for Trust in Care, manual handling, and first aid was due to be completed throughout the first half of 2017.

In the absence of good quality and consistent supervision, regular team meetings and adequate oversight, inspectors were not assured that sufficient progress had been

made to improve the practice of care in the units. These concerns and others issues relating to behaviour management, culture of care, institutional care practices and the lack of timely progress were escalated to senior management in Tusla following the inspection. In response, an oversight group consisting of senior managers from Tusla was established to co-ordinate the response to the management and action plans and ensure timely progress over a six month period. In addition the review by an external consultant was expanded to include a full strategic review of the service.

Judgment: Requires improvement

Standard 3: Monitoring

The Health Service Executive, for the purpose of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the Health Service Executive to monitor statutory and non-statutory children's residential centres.

Inspection Findings

At the time of the last inspection in August 2016, improvements were required in relation to:

- the response from the monitoring service during periods of crisis.

Since the last inspection, the monitoring officer had put in place a comprehensive plan to monitor the centre and service delivery improvements. This included monthly visits to the centre by two monitoring officers for six months beginning in November 2016. Further monitoring visits after that point would be risk based.

An inspector interviewed the monitoring officer and manager from the monitoring service as part of this inspection. The monitoring officer reviewed monthly reports and significant event notifications (SENs), and had regular phone contact with the Resident and Service Managers. They also met with the Regional Manager. In the event that SENs were of a serious nature, they were sent immediately to the monitoring officer.

At the time of this inspection, one monitoring visit had taken place and one report issued in December 2016 which was subsequently sent to HIQA. As part of this monitoring activity, the monitoring officer met the Regional Manager, Service Manager and Residential Manager, reviewed significant events and reports and followed up on the recommendations from the previous HIQA inspection and management action plan. The report made a number of recommendations in relation to quality assurance, supervision, team meetings and consultation with children, and a number of actions were agreed in response to these recommendations. The report outlined that further monthly visits would include interviews with staff and children.

Judgment: Meets standard

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.