An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 030

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Don Bosco Care**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Dates of Inspection	**16th and 17th of January 2020**
Registration Status:	**Registered from 13th of December 2017 to the 13th of December 2020**
Inspection Team:	**Eileen Woods** **Sinead Diggin**
Date Report Issued:	**29th May 2020**

Contents

1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 2003. At the time of this inspection the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from 13th of December 2017 to the 13th of December 2020.

The centre was registered to provide medium to long term care for up to five young people. There were four young people living in the centre at the time of the inspection. The centre's model of care was operated day to day on the therapeutic principles of belonging, safety and containment, communication and participation.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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 on the 3rd of April 2020 and to the relevant social work departments on the 3rd of April 2020. 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 30th of April 2020.

Although not all of the CAPA were implemented at the time the report issued the service were in the process of implementing the required actions. This deems 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: 030 without attached conditions from the 13th of December 2017 to the 13th of December 2020 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The Board of Management as the registered provider put arrangements in place to ensure that the centre operated in line with Children First Children First Act, 2015 and Children First: National Guidance for the Protection and Welfare of Children, 2017 through the director of services and the centre manager. Inspectors found that the centre had a child safeguarding statement in place as required and that the statement referenced the Children First Act, 2015 and Children First: National Guidance for the Protection and Welfare of Children, 2017. The centre's policies and procedures did not reference these and must now be updated to do so and to provide a clear set of procedures to guide staff regarding their role, responsibilities and procedures for reporting child protection and welfare concerns. Staff had completed training in the Tusla E-Learning module: Introduction to Children First, 2017. The centre manager had attended training regarding the role of designated liaison person, he was the named person for this role. There was no list of mandated persons created but it was understood by all that this fully qualified team were all mandated persons. The full staff team did not though present as fully knowing what this role entailed and must be provided with additional training and ongoing support to gain knowledge and expertise in practice.

The centre had a policy on safe practice that contained guidelines for staff on how to protect young people and how to act to minimise opportunities for abuse and exploitation. Inspectors found that the team were knowledgeable in this aspect of their work but not in the specifics of reporting of child protection concerns.
There was a policy detailing actions and interventions for countering and deterring bullying and there was evidence in practice that these procedures were implemented in practice both internally and externally where required to support a young person or the group of young people. The anti bullying policy had yet to be fully updated to reflect online and social media aspects and this must be done. The child safeguarding statement did address social media and online risks.

The staff team in interview and through written feedback displayed through their levels of experience and cohesion as a group that they implemented safeguarding

procedures in practice. There was evidence of leadership from the manager and of discussion and review through the monthly consultation sessions, weekly team meetings and handovers. There was no separate training for the staff in their safeguarding and child protection policies and procedures and this must be provided for the team once the policies and procedures have been updated. There should be regular and ongoing training in the prevention, detection and response to abuse. There was evidence through the files that the team and the key workers for the young people supported them to gain insight and self knowledge including how to protect themselves. The young people who met with inspectors stated that they could speak out in the community meetings, one to one with staff they trust and directly to the manager should they so wish. They confirmed that they had spoken to staff about their safety and their welfare.

There were safety plans created where specific additional safeguarding risks existed and the young people were consulted with along with their families and social workers as part of this. There was evidence of parental and guardian involvement in the day to day care and at times of vulnerability including incidents. There was evidence that parents would be notified of any incident or allegation of abuse.

Inspectors did not find a policy and procedure on protected disclosures in the main policy document and one must be included and circulated to staff. During interview staff displayed some knowledge of protected disclosures and its role in their work should the need arise. The director of service confirmed that work had been undertaken with the team about this.

Standard 3.2

The centre's model of care and therapeutic principles underlined a strengths and positives approach to the management and understanding of behaviours that challenge. Inspectors found that this was implemented in practice. There were polices on behaviour management, practices guidelines and monthly consultation for the team. The young people's information booklets and the centre's community meetings supported this work and the young people had clear knowledge of what to expect if they were to present with at risk behaviours. The team were trained in a recognised model of behaviour management with two relief staff pending training at the time of the inspection. The staff were confident and well informed about the model of care and had begun a process, in September 2019, of mapping their daily practice aims and objectives to the National Standards for Children's Residential Centres 2018 (HIQA).

The team had monthly therapeutic consultation sessions and weekly team meetings where the work of the team was guided and reflected upon to inform planning, review and outcomes. The team had processes in place to respond to and manage challenging behaviours through the use of dedicated plans related to crisis management as well as day to day care, these were regularly reviewed. Multidisciplinary meetings also took place, these were advocated for by the manager where the risks or concerns had escalated whether related to safety, mental health or addiction concerns for example.

The records of key working, one to one conversations, daily logs and community meetings contained evidence of work with each young person to assist them to gain insight into the impact on themselves and others of some behaviours. The young people named this very well to inspectors when talking about their experiences at the centre. One ultimate consequence can be the loss of a placement if the behaviours were deemed to be of a sufficient level of risk to others at the centre. There were general natural consequences in use and these were recorded and reviewed at the centre. There was also evidence of review and consultation with the young people around these.

The young people's files contained details of their history and why the placement in this centre was preferred. The team were aware of the historical information and sought to hold this in mind in their ongoing safeguarding. There were pre-admission risk assessments completed and these also took account of the group mix of young people.

There was some auditing taking place by the director of services who had tracked ongoing practices through unannounced and announced visits, meeting the staff and young people. They read significant event reports and consulted with the manager regarding responses and progress, they also attended team meetings regularly. The director of service was aware that a formal mechanism for quality assurance across all aspects of the centres functioning was required and that it must be mapped to the relevant national legislation and national standards and implementation in practice.

There were restrictive procedures in place as defined by the national standards through the use of bedroom door alarms, locked sitting room during education hours and there was not yet a formal mechanism in place to list, reassess and time limit any restrictions that may be put in place. There had been no restraints at the centre and a register existed to track these and there were provisions for staff post crisis debriefs

and life space interviews for young people should they be required. The centre must develope a procedure within their policy document to reflect restrictive practices.

Standard 3.3

The centre has a community meeting culture as part of its day to day therapeutic practices. Inspectors found that these were held throughout the week and the records maintained evidenced a clear, open and honest forum for all. There were records of any dissatisfaction raised by young people and the responses and outcomes were recorded. The manager also attended some community meetings and young people can chair and set agendas. The director of service reviewed these records from time to time. Staff utilised their own team meetings, reflective practice at handovers and supervision to identify areas for improvement. The team's main concern, which had been brought up by them to the manager, the director and to the board was the impact on staffing through budget cuts.

The centre did not have a co-ordinated formal mechanism in place for gathering general feedback to inform the development of the centre. The director of service was aware of this as an area that will require action. The team did have a high level of ongoing contact with family and responded to their input and observations on an ongoing basis.

There was an accurate and up to date policy on significant events available to staff. Inspectors found that the team reported significant events effectively and efficiently to the relevant parties including verbally to the relevant involved parents and significant others. There was evidence of follow up with the parties to inform practice and interventions at the centre. The policy in place was reflected in practice. The manager had oversight of all significant events and all follow up actions. The manager ensured that actions were implemented through mediation, community meetings, professionals' meetings, consequences, crisis management plan reviews and team meetings. The learning taken from these had informed the development of admissions procedures for the centre and management of the group dynamic. There was also an organisational significant event review group that had not been as active for a period of time but who were recommitted to meeting every six to eight weeks again for the future.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.3**
Practices met the required standard in some respects only	**Standard 3.2**
Practices did not meet the required standard	**Standard 3.1**

Actions required

- The director of service and the board of management must ensure that the policy and procedure documents are updated in line with Children First Act, 2015 and Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The management must ensure that additional training is provided to the team in child protection and safeguarding inclusive of the centres child protection and safeguarding policies and procedures.
- The anti bullying policy must be updated to reflect social media and online risks.
- The director of service and the board of management must ensure that a policy on protected disclosure is developed and implemented.
- The director of service and the centre manager must create a system for recording and reviewing restrictive practices.
- The centre manager and director of service must ensure that the use of restrictive procedures is individually risk assessed, recorded on each young person's care record and monitored on an on-going basis.
- The director of service must develope and implement a system of written regular and relevant auditing and monitoring of practice at the centre.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The director of service informed the inspectors that the organisations policies and procedures had been reviewed through an organisational policy review group in 2019 but had not been updated inline fully with the National Standards for Children's

Residential Centres, 2018 (HIQA) or as stated with Children First: National Guidance for the Protection and Welfare of Children, 2017. The director of service must ensure that they are developed and implemented within a focused timeframe.
With the exception of some child protection procedures staff in interview had a good understanding of the policies and procedures relating to the areas examined as part of this inspection and had some working knowledge of the new National Standards for Children's Residential Centres, 2018 (HIQA). The inspectors also viewed this across centre records, young people's files and staff supervision records.

Standard 5.2

There was an up to date and available organisational structure for this voluntary body with persons, posts and responsibilities assigned at all levels. The centre manager was experienced and had been in post throughout the centre's development into its model of therapeutic care and purpose and function. The staff identified good quality leadership in all aspects of their work and for their part the manager and the director named the excellent commitment displayed by the staff during a period of time where there have been vacancies on the staff team and financial uncertainty. The director of service provided support for the centre and its aims through the funding allocation for a specialist consultant on a monthly basis. There was a commitment to good care, safety and training but these had been impacted upon by budget restrictions, staffing issues and a lack of access to more diverse training.

The director of service and chairperson of the board of management outlined that the 2019 service level agreement had not been signed but that they hoped that the 2020 service level agreement would be signed off. There were ongoing negotiations taking place.

The person in charge was deemed to be the centre manager and they had systems in place to take responsibility for all aspects of the day to day running of the centre. There was an internal management structure but this had been affected by periods of leave and inspectors were informed that budgetary issues affected their capacity to temporarily fill those posts.

The management had maintained schedules for review of operational policies and procedures and as stated will be implementing another review to bring these fully in line with national standards, guidelines and legislation.
The policies as presented did contain a risk management framework to form the basis of one combined risk structure and inspectors recommended to the management in

feedback that they review and combine the various relevant aspects of the policies. There were risk management and risk reduction practices in place with the young people and some had yielded improvements in quality of life for the young people. Inspectors had recommended that one area of safety planning be updated and kept live for ongoing review. There was an on call system in place for staff to access in an emergency or for advice outside of hours. The director of service had established an organisational risk register and this register evidenced items relevant to the centre and the measures in place to manage the identified risks or the planned measures and their likely impact.

The manager outlined that instead of three social care leaders that at the time of the inspection there was one social care leader in their role due to a variety of reasons. Each social care leader post had named delegated duties, the manager and other staff were assisting with tasks until the posts are filled. There were vacancies on the team and therefore there were limitations in the amount of delegating that the manager could undertake regarding their duties and also regarding who covered for their absences.

Standard 5.3

There was a centre statement of purpose and function that was accurate and up to date, it had been reviewed in 2019. The ethos, model of care and staff aims in delivering on the model of care was clearly outlined. The staff team, the service provided and what young people could benefit from it were included. The age range, gender, needs and specific services available at the centre were named as were the safe care and safety arrangements.

The day to day work at the centre, discussion and feedback from staff, direct discussion with the young people and inspectors observations found that the purpose and function was upheld daily by the team and the management. The social workers for the young people were happy with the care and consistency provided to the young people at the centre and found it to be congruent with the purpose and function as presented to them.

The work of the centre was outlined for young people during their transitions and at pre placement meetings as well as in writing. There were booklets and/or information for children, families and professionals about the centre.

Standard 5.4

There was evidence that the quality of practice at the centre was reviewed and that a focus was maintained on ongoing development of care delivery. This was evident in the work of the management internal and external and in the management meetings, the board meetings and the supervision between the manager and the director. What was not in place was a system of audit or quality assurance through which to measure the practices against the National Standards for Children's Residential Centres 2018 (HIQA) and the relevant national guidelines and legislation.

The director of service relied on the accurate reporting of complaints, manager's reports, management meetings and their own review of registers and selected records from time to time. They were aware that they required a dedicated system for the co-ordinated oversight of complaints. They stated that certain areas for development had been impacted by the uncertainty around budgets and budget negotiations. They committed to address their audit and quality assurance responsibilities in 2020. The board of management prepare an annual report. The manager prepared monthly reports and there were monthly management meeting with minute's maintained of all. The director of service prepares reports for the board and circulates information and policies to the board also. They organisation will need to implement an annual system of review of compliance with the centres objectives.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.2** **Regulation 6.1**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 5.2** **Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.1** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The management must ensure that the policies and procedures are updated in line with the National Standards for Children's Residential Centres HIQA 2018
- The director of service must implement a quality assurance system that takes account of monitoring of complaints, concerns and incidents.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director of service and the board of management must ensure that the policy and procedure documents are updated in line with Children First Act, 2015 and Children First: National Guidance for the Protection and Welfare of Children, 2017.	Currently in the process of updating the Policy and Statement. Statement to be sent to Limerick for validation. We hope to have this in place following validation by 1st July 2020.	To be updated every 2 years or if new Legislation is put in place in the meantime. To be updated in accordance.
	The management must ensure that additional training is provided to the team in child protection and safeguarding inclusive of the centres child protection and safeguarding policies and procedures.	Following COVID 19 restrictions being lifted. Additional Training to be put in place for all staff in child protection and safeguarding.	To be updated every two years in line with Children First Guidelines.
	The anti-bullying policy must be updated to reflect social media and online risks.	In the process of being updated. To be in place by 1st July 2020.	To be reviewed every two years.
	The director of service and the board of	This is in the process of being completed.	To be reviewed every two years.

	management must ensure that a policy on protected disclosure is developed and implemented.	To be in place by 1st September 2020	
	The director of service and the centre manager must create a system for recording and reviewing restrictive practices.	We are in the process of completing risk assessments for restrictive practices. To be completed by 1st June 2020.	To be updated and reviewed as necessary.
	The centre manager and director of service must ensure that the use of restrictive procedures is individually risk assessed, recorded on each young person's care record and monitored on an on-going basis.	We are in the process of completing risk assessments and updating individual risk assessments. To be completed by 1st June 2020	To be updated and reviewed as necessary.
	The director of service must develop and implement a system of written regular and relevant auditing and monitoring of practice at the centre.	Awaiting Audit Tools developed to assist us in this process. It is envisaged this will be completed by 1st September 2020	Tools updated in line with standards and updates.
5	The management must ensure that the policies and procedures are updated in line with the National Standards for Children's Residential Centres HIQA 2018	In the process of completing. To be completed by September 2020	To be reviewed in line with National Standards for Children's Residential Centres HIQA 2018.

	The director of service must implement a quality assurance system that takes account of monitoring of complaints, concerns and incidents.	In the process. To be in place by September 2020.	To be reviewed in line with Standards.