An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 081**

**Year: 2021**

# Inspection Report

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|---|---|
| **Year:** | **2021** |
| **Name of Organisation:** | **Homeless Girls Society** |
| **Registered Capacity:** | **Six young people** |
| **Type of Inspection:** | **Announced** |
| **Date of inspection:** | **04th & 05th of February 2021** |
| **Registration Status:** | **Registered from the 31st of July 2019 to the 31st of July 2022.** |
| **Inspection Team:** | **Eileen Woods**<br>**Lorraine Egan** |
| **Date Report Issued:** | **20th April 2021** |

# 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 in 2001. At the time of this inspection the centre was in its seventh registration and was in year two of the cycle. The centre was registered without attached conditions from the 31st of July 2019 to the 31st of July 2022.

The centre was registered to provide short to medium term care for up to five young women, aged 13 to 17, with a sixth bed dedicated for emergency use through referral from the Tusla out of hours' service. The team worked in compliance with the guiding principles of this voluntary body and followed a model of providing a safe, secure and homely environment where young people can begin to build trust and positive life experiences through appropriate adult relationships and role modelling provided by the team. There were four young people living in the centre at the time of the inspection.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| 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. Due to the Covid-19 pandemic, communication with the centre manager and risk assessments took place and it was determined that this inspection be conducted with a blend of remote and onsite processes.

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 22nd of March 2021 and to the relevant social work departments on the 22nd of March 2021. 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 2nd of April 2021. 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: 081 without attached conditions from the 31st of July 2019 to 31st of July 2022 pursuant to Part VIII, 1991 Child Care Act.

# 3. Inspection Findings

**Regulation 16 Notification of Significant Events**

**Theme 3: Safe Care and Support**

**Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.**

The centre had a set of policies and procedures in place regarding child protection and safeguarding. Inspectors established that the team's practices and some of their other reporting flow documents were accurate and in line with Children First, the main policy and procedure document required revision in order to be aligned with Children First: National Guidance for the Protection and Welfare of Children 2017.

The centre's policies and procedures governing child protection reporting, under a range of categories, must be revised to bring them into full compliance with the Children First: National Guidance for the Protection and Welfare of Children, 2017. Tusla, The Child and Family Agency have a set of guidance and advice documents including a comprehensive publication Child Safeguarding: a guide to policy procedures and practice, Version 2, 2018 that can support this revision. The key areas that must be updated related to the inclusion of the role of the DLP throughout, the reporting procedures for all types of mandated and non-mandated reporting and the procedure for dealing with information that does not meet the threshold for reporting through the portal system.

There was robust evidence on file of good quality safeguarding and protection of vulnerable young people in day to day work. The practices recorded on file exceeded the policy knowledge and there was evidence of good daily practice on thresholds for identifying and acting to reduce or remove risk specific to child protection. All young people had safeguarding plans on file, these were reviewed weekly or where required and there was collaborative interagency work with the young people and the professionals involved in their care.

The inspectors also advised that the main policy and procedure document layout be revised to link the relevant child protection and safeguarding policies and procedures into a dedicated section with the general policies organised adjacent to this. The centre had received training in all three available national online training modules and had consultation at team level from a Tusla Children First Information and Advice Officer.

The team knowledge at interview and on questionnaires highlighted aspects of Children First that required ongoing clarifying and learning related to the areas noted above. The team must also revise their awareness of the policies that inform and complement good safeguarding.

The centre management had established a tracking and register system for child protection and welfare reporting forms that had been reported through the online portal system. All staff had been registered for the portal. The trackers were very well maintained with follow up evidenced throughout. Due to the short length of stay at the centre the centre management had implemented follow up with social workers to establish that the referrals had been closed, were open but being managed by Tusla or if the centre may have an ongoing role. The centre management had audited their own trackers.

The young people had risk assessments and safeguarding plans, there was collaborative work with families, social workers, the Gardaí and Guardians ad litem. The plans and documents reviewed were detailed and showed the good relationships forged by centre with the social work departments and the young people. There was evidence that knowledge was used appropriately for young people's safety and wellbeing. The key working and the young people's meeting records highlighted that work was done by the staff on both a planned and an opportunity led basis to advise, support and empower vulnerable young people.

The centre staff had access to and displayed knowledge of the policy on protected disclosures. The policy dealt appropriately with the centres status as a voluntary body and the key role of the chairperson.

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

The staff team implemented a model of care based on a strengths and positives based approach. The approach had been reflected in the statement of purpose and function and in the behaviour management policy where it was included as a 'positive behaviour management programme' incorporating positive books, treat and comfort boxes, a points system and a physical environment reflecting positive messages. The overall goal being the creation of a sense of safety and being cared for during their stay. The young people's rights were contained within the 'consultation and young people's rights' policies and the staff team were knowledgeable about the principles, national policies and legislative frameworks governing these. The social workers for the four young people and the three young people who met with an inspector named that they felt safe, happy and well cared for by the team when in the centre.

The centre management and staff had identified an area of development in further framing their positive behaviour support programme and were working with a Psychologist to finalise a positive behaviour manual for the team. The manual was developed in consultation with the team and some young people and was awaiting final approval by the board of management. This laid out the ethos, theoretical and evidenced based references that underpin the approach. The manual and the centre policy also outlined the practices through which challenging behaviour was addressed. The staff utilised their training in two models of managing behaviours that challenge, these were compatible with one another and the majority of the staff team had trained in both, there was a training plan in place for those outstanding to be completed.

The team worked with the admissions information, consultation with young people and their social workers to create a set of plans that were regularly reviewed thereafter to understand and respond to challenging behaviour. Where issues related to mental health became prominent there was evidence of the centre team working with the relevant clinical and national mental health support services to respond to the young people's distress.

The centre had anti-bullying, anti-discrimination and rights policies in place. They had worked with a specialist in gender based issues to add to the team's skills. The centre's guiding principles featured a commitment to respect as core to the centres values and this was evident throughout the work at the centre. There was a strong focus on both mutual respect and on protecting young people.

The centre had a policy in place on restrictive practices which was developed in line with the requirements of the criteria contained within the National Standards for Children's Residential Centres (HIQA) 2018. The policy named a range of standing or ongoing restrictive practices and the reasons for their inclusion. For example, the kitchens in the basement were subject to advice by Dublin City Fire brigade to be locked at night and given the lay out of the two properties mitigating responses had been put in place by the placing of snack facilities on the upper two bedroom floors. Any restrictive practices were decided through the use of a risk assessment and a record placed on each young person's file. The centre management audited these and reviewed them with the team.

**Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.**

The centre had a colourful and informative booklet in place for young people and the young people who met with inspectors gave positive feedback about the centre. They had a young people's meeting every week with staff as one avenue to have discussions. Other avenues were through their key working sessions and chats with the managers and staff. They had an additional opportunity to give feedback when leaving the centre. The staff participated in weekly team meetings, handovers, reflective practice, supervision, SWOT analyses and audits in order to discuss ongoing issues and to contribute to practice development at the centre.

Social workers had been asked to provide verbal feedback previously and the centre now has a formal feedback form developed and ready to implement. Discussions with family take place verbally and any complaints from family had been addressed in the past. There was evidence that changes had taken place on foot of comments from young people or in response to the new demands arising from the pandemic such as the availability of Wi-Fi throughout the house.

The centre operated a significant event reporting system based on the existing Tusla standardised policy and procedure on the significant events. Inspectors found that the team were experienced in reporting significant events and knew what constituted an incident and needed to be reported. Training on report writing had taken place and notifications were clearly written, sent without delay to the relevant persons and entered onto a register of significant events. The register noted all incidents inclusive of missing child from care, child protection reports made and formal complaints. This register was evidenced as tracked and then audited internally. Incidents that were more serious, for example involving violence were subject to formal significant event review and debriefing at the centre. The team discussed these at team meetings and identified actions required to address follow up.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 16** |

| **Compliance with standards** | |
|---|---|
| **Practices met the required standard** | **Standard 3.3**<br>**Standard 3.2** |
| **Practices met the required standard in some respects only** | **Standard 3.1** |
| **Practices did not meet the required standard** | **None identified** |

**Actions required**

- The centre management must ensure that child protection policies are reviewed to ensure full compliance with Children First, National Guidance for the Protection and Welfare of Children, 2017.
- The registered provider and centre manager must review the child protection policy and procedure team training to ensure that each member of the staff team is confident and competent in all aspects of child protection and safeguarding policies and procedures.

**Regulations 5 Care Practices and Operational Policies**
**Regulation 6 (1 and 2) Person in Charge**

**Theme 5: Leadership, Governance and Management**

**Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.**

The registered provider of this centre was the Board of Management through its Chairperson. The day to day operation of the centre was run by an experienced centre manager and deputy manager. The Board was actively engaged in the oversight of the completion of a set of policies and procedures that were developed to meet the requirements of the centre to operate in compliance with the relevant statutory, regulatory and relevant national standards, National Standards for Children's Residential Centres, 2018 (HIQA). The policy document and the staff handbook had been revised through a structured process in January 2021.

The policy document, titled 'Child Safeguarding policy and procedures 2021' contained the staff working policies for their day to day practice. There was a separate statement of purpose and function, model of care manual (under development) and a comprehensive staff handbook, all of which had also been revised. The inspectors recommend that the centre combine their purpose and function, model of care and general policies into a combined document with the child safeguarding policies alongside these. The statement and the policies informed each other and linked well to form the overall picture of care provision at the centre. The 2021 policies had been updated to reflect new and existing legislation and as stated under Theme 3 must be again revised to be accurately in line with Children First. The centre management had initiated internal auditing and a quality improvement

framework designed to identify any gaps in compliance. The lack of an external auditing option that looked at policy content, compliance, practices and to advise the centre management and the Board regarding updates and gaps was evident as an area requiring action that would benefit the centre. The Board and the centre management had identified this as an area they wished to develop also.

The staff at the centre demonstrated good general working knowledge of the policies and procedures, regulatory requirements and changes in legislation such as the General Data Protection Regulation 2018 and how it pertained to their work. There was evidence at team meetings of discussion and circulation of policies particularly newer or updated policies, for example whistle blowing policy.

**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.**

The centre had a well-established leadership structure of a centre manager, a deputy centre manager and three social care leaders. The roles and responsibilities of all those in senior posts were agreed with the Board of Management and known by all staff and professionals dealing with the centre on a day to day basis. The inspectors heard positive feedback from external professionals about standards in care and communication demonstrated by the centre management and team. The staff team informed inspectors that they were supported day to day to provide the quality of care required for this busy service. The social care leaders operated as part of the roster and the centre had adequate numbers of qualified and experienced staff appropriate to the purpose and function of the centre. Six weekly internal management meetings were held and recorded to a good standard, the records noted accountability, policy, risk management, key working among other areas and there were actions and follow up completed.

The centre manager was the named person in charge, their deputy manager operated the centre with them Monday to Friday and acted for them in their absence. The centre manager reported to the Board six times a year. The centre manager had a delegation structure established for the senior team and this document was kept under review. The work of the team was audited by the centre manager and the deputy manager to a good standard and they and their Board have been seeking a means by which they can have external audits conducted to further enhance their governance structures.

The lines of accountability and reporting to the Board were clearly structured and the secretary and chairperson of the board both outlined that the Board was meeting its requirements and happy with both the management and care provided at the centre. The Board were in a process of further development in line with the statutory requirements for charities.

The centre had a service level agreement for 2020, they had their last service level agreement meeting in 2018 and were awaiting mutually agreeable dates for a 2021 meeting to discuss the next agreement. The Board want to urgently secure the future of this centre and have taken ongoing steps in governance and development to continue to be a well-functioning resource for children in crisis.

The 2021 policy and procedure document contained a policy and procedure for risk assessment and there was also a separate risk management policy. Both the policies outlined the procedures for daily practice in the use of risk assessment and the procedures for the organisational or broader centre risks and how these were managed. The policies were clear and specific and could be helpfully brought together in the main policy document. There were records relating to risk assessment completed and these were stored on the young people's files. The team discussed and reviewed these with the young people where possible, the management, the team and external professionals such as social workers where required. Inspectors found that the team were knowledgeable about managing daily risks and the procedures in place around same.

The deputy manager co-ordinated the centres risk management framework and its risk register. The register was organised into organisational risk and centre risks with clear forms and matrix in place developed from an evidenced based risk management model. The Board confirmed that they oversaw the risk register, the risk records were well organised and overseen at the centre by the deputy manager and there were actions and outcomes rated, recorded and reviewed. There was also a separate risk management framework in the staff handbook and this contained the risk rating matrix utilised to inform the risks in relation to the young people, premises or operational risks.

One aspect of risk management practice that has been in place was the historical inclusion of a drug testing consent form as standard upon admission, with changing systems and approaches to areas such as these inspectors recommended that this be

dispensed with. In reality practice decisions such as these took place on a case by case basis when identified, justified, discussed and collaboratively agreed.

In response to the covid-19 pandemic the centre had worked to rapidly implement infection and hygiene control measures. They developed guidelines 'Work Safely Protocol Covid-19' and policy for staff and young people, keeping all informed at key moments throughout the pandemic to date in line with government and public health guidelines and requirements. The management were the named Covid officers with two additional named staff as assistants. The staff had completed the available HSE training, the centre managers provided a Covid on call service additional to the general on call and the centre had implemented any advisories issued by Tusla, The Child and Family Agency. The centre had sanitising equipment, cleaning schedules and an area dedicated to an isolation space should the need arise, this was developed in a manner designed to ensure a young person would still have access to suitable facilities and close proximity to staff.

**Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.**

The centres statement of purpose and function was reviewed in 2020 and outlined the aims, objectives and guiding principles of the centre. It was descriptive and informative about the centre particularly regarding its commitment to the young people and how this was delivered. The approach in place which was to be safe, nurturing, to build good relationships and positive life experiences was named in the statement. The actual numbers of staff and management were not named and should be added.

The staff implementation day to day of the purpose and function was evident to inspectors through the staff meetings, handovers, case management meetings, young peoples and staff meetings. The young people informed the inspector that they were safe and well cared for in the centre and had keyworkers and others available to them to help them get things done and support them. They said there was support for their schooling during the lock down and despite this being a short term placement that they had fun together with staff and relationships were established. The six month placements did extend onward for some young people particularly where there were complex issues or issues relating to entitlement to aftercare from Tusla.

The operation of the centre in line with its purpose and function was informed by feedback from young people who had left the centre and there were new forms in

place for social workers to provide feedback also. The managers stated that they strive to get verbal feedback from parents and significant adults in the young people lives and hoped to capture more of this formally. The social workers interviewed by the inspectors gave positive feedback of the work completed at the centre with and for the young people, the advocating done on behalf of the young people and the standard of communication from the team.

**Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.**

The centre management conducted quarterly audits, the social care leaders conducted monthly and two monthly audits on identified areas of practice with a central focus on key working, named as mentoring in this centre. The management quarterly audits in 2020 looked at areas including staff files, supervision, files and registers, there were two monthly audits of young people's care files. Each audit template had recommendations, actions, persons responsible named and outcomes to support ongoing compliance. Inspectors found that the systems the centre management had implemented to meet ongoing governance requirements were of a good standard and were subject to ongoing development regarding their effectiveness. There was a robust focus on quality of care, safety for young people and continuity through consistent adults working in an informed way with them. The centre management evidenced efforts to address comments and complaints arising and may need to look at how to continue to add to that process by tracking informal complaints and then having an external audit conducted of the specifics and of any trends. The centre management had developed a quality improvement plan in 2020 and were actively tracking this.

The Board and the centre management were researching how to engage suitable external auditing to add to the existing governance system. Agreeing the next service level agreement and clarifying the future of the centre was central to that.

Inspectors reviewed evidence of the communications between the Board and the centre management that confirmed their active role in compliance relating to standards, the mission and model of the centre, the code of conduct, policies and they were completing a compliance checklist to further structure this work. The centre manager reported formally to the Board on a two monthly basis and completed a governor's report which was submitted in advance of these meetings. There were minutes maintained of all board meetings. The secretary of the Board and the

chairperson of the Board both stated that they were happy with the commitment and standard of care displayed by the management and staff at the centre. The members of the board were a mix of skills, were experienced and committed.

The outcomes of audits and the quality improvement plan had been reported to the Board and there was an ongoing pilot in place to complete an annual review of compliance which included opportunities for improvement. Much of the review work was informed by a centre SWOT (strengths, weaknesses, opportunities, threats) analysis done by management, staff and the Board and by the audits. Individual SWOT analyses and a young person's feedback was completed at the end of a young person's placement. There was also a social worker's feedback form developed and due to be implemented in 2021.

Inspectors found that the centre management and the Board had acted to implement governance, policy and oversight structures in line with the National Standards for Children's Residential Centre (HIQA) 2018. Now that the centre has these mechanisms in place it would be beneficial for them to highlight more of the extracted learnings from the audits in relation to policies, regulations, legislation and from significant events reviews, complaints and outcomes to child protection issues.

| **Compliance with Regulation** | |
|---|---|
| **Regulation met** | **Regulation 5**<br>**Regulation 6.2**<br>**Regulation 6.1** |
| **Regulation not met** | **None identified** |

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

**Actions required**

- The centre management and the Board of Management must further develop their auditing structure to generate information related to policy compliance, processes related to complaints, concerns and incidents and the learning from the outcomes.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| **3** | The centre management must ensure that child protection policies are reviewed to ensure full compliance with Children First, National Guidance for the Protection and Welfare of Children, 2017. | The centre management are currently in the process of reviewing the centres child protection policies to ensure full compliance with Children's First: National Guidance for the Protection and Welfare of Children 2017. This will be completed by 30th April 2021. | The centre management have developed an audit tool in line with Child Safeguarding Children's first TUSLA guidance document. This will now be included as part of our audit system. |
| | The registered provider and centre manager must review the child protection policy and procedure team training to ensure that each member of the staff team is confident and competent in all aspects of child protection and safeguarding policies and procedures. | On completion of the review of the centres Child Protection policies we will conduct a training needs analysis to inform our in-house training strategy, we will be guided by TUSLA Best Practice Principles for organisations in developing Children's first training programmes.<br><br>Where available we will augment in house training with external training by TUSLA. | The centre management will oversee and ensure that these discussions are taking place at team meetings and supervision. This will form part of our supervision audits and our training needs analysis audit.<br><br>This will be an ongoing process. |

| | | | |
|---|---|---|---|
| | | Child Protection Policy and team training in Child Safeguarding will a standing item on the agenda at team meetings and supervision.<br><br>A plan will be implemented to discuss in sequence each Theme, Policy and Protocol of our revised Child Protection Policies at our team meetings so as to ensure that all staff are confident and competent in all aspects of child protection and safeguarding policies and procedures. This will be an ongoing process. | |
| **5** | The centre management and the Board of Management must further develop their auditing structure to generate information related to policy compliance, processes related to complaints, concerns and incidents and the learning from the outcomes. | The centre management and Board of Management are further developing their auditing system to include the key learning from these. This will be also included in the SEN audits.<br>At the next Board of management meeting in April 2021 the appointment of an external auditor will be further explored. | This will be kept on the agenda of the Board of Management meetings and internal management meetings.<br>This will also be reviewed at our annual audit of compliance. |