Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 030

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Don Bosco**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Date of inspection:	**20th & 21st July 2021**
Registration Status:	**Registered from 13th December 2020 to the 13th December 2023**
Inspection Team:	**Lisa Tobin** **Lorraine Egan**
Date Report Issued:	**26th October 2021**

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1. Information about the inspection process

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of 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 2003. At the time of this inspection the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions from 13th December 2020 to 13th December 2023.

The centre was registered to provide medium to long term care for five young people from 12-17 years on admission. The centre's model of care was operated on the therapeutic principles of belonging, safety and containment, communication and participation. There were three 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
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation 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. The inspection was a blended inspection where inspectors spent time on site and completed interviews via teleconference.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 14th September 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 11th October 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: 030, without attached conditions from the 13th December 2020 to the 13th December 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development

It was evident to the inspectors that the care and attention given to the young people from the staff was of priority and that the staff had the best interests of the young people at the centre of their work. The three young people at the centre all had a relevant and up to date care plan on file. There had been a delay in receiving one care plan due to the recent cyber-attack. Inspectors reviewed contact between the centre manager, staff and the social worker where requests were made for the care plan and the allocated social worker confirmed the care plan had been posted to the centre.

The placement plans for each young person were written by the key workers and were linked to goals set out in their care plans. The placement plans were reviewed monthly by the key worker and updated as required. There were key working weekly forms for each young person which identified different areas addressed and a set goal to be completed. For some young people goals were met and documented through key working or individual work but there were also goals unmet that would remain on the placement plan into the following month.

Inspectors noted that there was a difference in timelines as to when the placement plans were updated for each young person. Inspectors noted gaps in the placement plans regarding assigning responsibilities to staff and completion dates. The section for completion date was constantly referred to as ongoing, which gave the indication the tasks were never completed. The placement plans were repetitive which showed little change each month despite work being completed with the young people. The outcomes need to be addressed clearly in the placement plans. Further development around the formatting and execution of the placement plans was required in order to detail the specific work completed with the young people. Staff need to identify the type of work that was completed during the month whether that was individual work, key working or involvement with external supports or services. The young people were informed informally about tasks that were identified within their placement

plans as staff stated a more structured format resulted in non-engagement from the young people.

Inspectors reviewed key working documents completed with the young people which reflected goals identified in the placement plan, however for some young people there was a deficit in the number of key working sessions taking place due to non-engagement from the young people and being missing from the centre. All attempts of work with the young people should be documented even if there was non-engagement from the young person. This would effectively show the work that the care staff are trying to implement with the young people.

The young people were offered to part take in their child in care reviews, however staff stated they usually refused. The statutory reviews were occurring in line with regulation. The young people had the opportunity to complete reviews forms to ensure their voices were heard. Their family members were also given the same opportunities.

The young people were supported by several external agencies during their placement which had been identified in their care plans including counselling, clinical psychologist, juvenile liaison officer, extern, community gardai, CAMHS and the education welfare officer. Communication with these agencies was evident during the file review. There was regular communication between the centre and the allocated social worker which was very effective as stated by them during interview. The allocated social workers spoke positively about the care the young people were receiving while residing in the centre. Inspectors noted that there were few recorded contacts with social workers in the young people's files, however inspectors were informed by both staff and the social workers that contact was frequent. Inspectors noted that there was regular contact with the young people's families where they were updated about all aspects of the young people's care. The centre manager must ensure that all contacts are written up and recorded to show the work undertaken.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 2.2**

Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that placement plans are completed correctly with appropriate details regarding time frames, allocation of tasks and completion of work.
- The centre manager must ensure that all contacts are written up and recorded to show the work undertaken.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

There were three changes of managerial roles within the organisation which occurred recently. There was a new manager appointed in June 2021 who was responsible for the overall leadership in the centre and was appropriately qualified and experienced for the role. The centre manager had worked within the organisation for the past 15 years and was aware of the young people's needs when taking on the new role. Currently there was no deputy manager in position as funding was not available to recruit a suitable person. The centre manager showed leadership through oversight of the daily files, supervision and leading the team meetings. The centre manager worked closely with the director of service to ensure the quality and safety within the centre was maintained through daily contact by phone or email and by onsite visits to the centre.

Governance arrangements within the centre were currently being reviewed with new audit protocols being introduced around supervision, training and risk management. The director of service had completed file audits on the young people's files and feedback meetings occurred after the review with relevant people. Feedback actions were very detailed, and the centre manager took responsibility in addressing the actions required. A social care leader within the organisation was newly appointed to take over the young people's file audits as part of the new governance system. New

audit tools were being created in line with the national standards, however these have been delayed due to Covid-19 and several managers being on unavoidable leave at the same time.

Inspectors reviewed a sample of both the team meeting minutes and the senior management minutes. A new format for the team meetings would be recommended as the current format showed discussion of the young people and one or two other items. The meeting minutes did not reflect the work being completed and what was evidenced by the inspectors. The inspectors would recommend that policies, standards, risk assessments, complaints, significant events, reviewing young people's placement plans, young people's meetings and training are discussed at team meetings or part of a rolling agenda.

The sample of manager meeting minutes that were reviewed showed repetition in the young people's notes from the previous month and only discussed one of the young people from the centre. Oversight was shown regarding updates to policy and audits for young people's files but there was no evidence of oversight regarding significant events, SERGs or compliance reports in line with the national standards. The gaps in governance oversight had been acknowledged by senior management and they were attempting to rectify the deficits.

During interviews the staff were knowledgeable of the structures within the organisation including the applicable roles of responsibilities of all staff in the centre. There was a service level agreement in place and the director of service was in regular contact with Tusla about the services provided.

The centre manager in partnership with the director of service were responsible for the overall accountability, responsibility and authority for the delivery of service in place in the centre. The policies and procedures for the centre were updated in 2020 and a policy review group was established. New policies being introduced included bullying in the workplace, staff handbook, health and safety and recruitment.

There was a risk management framework in place which included an organisational risk register, pre-admission collective risk assessments, ICMP's, IAMP's and individual risk assessments for the young people. The risk management framework and the supporting structures required further development including a policy. The organisational risk register in place was dated November 2019 and the last item updated was in June 2020. It was not evident to inspectors who reviews the register or how often it was reviewed. The pre-admission risk assessments for some young

people were vague in the identification of risk, the potential impact on other young people and how the risks were to be managed for the individual. Individual risk assessments were put in place for new or concerning behaviours. There was currently no centre risk register, however the centre manager stated that they intend to implement this. During interviews, staff awareness of the risk management framework was not sufficient and further work was required with the team around risk management. The centre manager informed the director of service daily through written updates of any concerns, issues or risks that occurred in the centre.

During interview with the director of service, it was highlighted to inspectors how the service would benefit from further managerial posts such as a deputy manager and deputy director in order to support the oversight and governance of the organisation, however again due to funding restrictions, these posts have not been developed. When the centre manager was absent, the social care leaders covered the managers role and completed the tasks together. There was no delegation log in place or written record of duties undertaken. The centre manager stated this will be implemented.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must ensure that appropriate governance oversight was in place in the centre to ensure compliance with the National Standards for Children's Residential Centres (HIQA) 2018.
- The centre manager must create a new format for team meetings to show the oversight of work completed with the young people and include relevant topics for discussion which will add to the overall governance management of the centre.
- The director of service must ensure that significant events, complaints and concerns are discussed at senior level collectively to account for reviewing and analysing trends that occur.

- The director of service and the centre manager must review the risk management framework in place and create a relevant policy and procedure. The details in the pre-admission risk assessment must be updated. The staff must undertake training around the risk management framework.
- The centre manager must establish a centre risk register and a delegation log for tasks/duties undertaken by staff.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

There was evidence of workforce planning through the recruitment and retention of staff within the centre. The roster was overseen by the centre manager. There was an appropriate number of staffing in the centre in line with the centres statement of purpose and function. Staff had a social care qualification or a relevant recognised degree in compliance with regulation on staffing. There was one post vacant since March 2021. The director of services and centre manager must ensure that vacancies were filled in an appropriate timeframe.

The inspectors reviewed a sample of personnel files which showed three references for each staff member, their qualifications and verification of these. However, there were many deficits noted regarding staff mandatory training. On request of the training analysis, inspectors noted that there was no staff member fully trained in a recognised behaviour management model. Two staff were trained in the relevant theory, three had no training at all and eight were out of date significantly. Training was due to occur in September 2021. Most staff were due a refresher for first aid in September 2021. Manual handling, model of care, fire training, GDPR, medication and risk assessment training were all required by the team. The registered proprietor must ensure that staff receive all relevant mandatory training. Inspectors were informed the reason for the deficits were due to covid and a lack of services providing the training required. Staff did not use physical interventions with the young people while awaiting refresher training. Staff used their theory knowledge of the training to deescalate incidents and if needed garda intervention was sourced.

There was a relief panel in place which was used regularly as noted by inspectors reviewing the roster. The relief panel were currently filling the vacant line. The relief staff also covered annual leave, sick leave, maternity leave, parental leave and were appropriately qualified. Covid emergency cover was supported by the relief staff.

Some of the staff in the centre have worked there for up to 20 years which showed dedication to the centre and organisation. During staff interviews inspectors were informed of supports available to the team and reasons why the team remained in the centre included EAP, external training, staff support, good working conditions, ways of working and the underlying ethos of the centre.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The director of services and centre manager must ensure that vacancies are filled in an appropriate timeframe.
- The registered proprietor must ensure that staff receive all relevant mandatory training.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that placement plans are completed correctly with appropriate details regarding time frames, allocation of tasks and completion of work.	Centre manager addressed the requirement for all placement plans to be accurate in detail and time at the team meeting on 21.9.21. Placements plans will now be brought to team meetings in a scheduled way along with continued oversight from manager and Social care leaders. Format of Placement Plans has been altered slightly to clearly list goals/ actions under relevant headings	Centre manager will meet with keyworkers every 6 to 8 weeks in a focus meeting to discuss and review the placement plans for their key child. The placement plans will also be reviewed at a team meeting every 4 to 6 weeks by the whole team to ensure maximum input and decision making.
	The centre manager must ensure that all contacts are written up and recorded to show the work undertaken.	Centre manager has addressed the need for all contacts to be written up in a timely fashion at team meeting level, team will implement plan of increased time management and ring fencing admin time off the floor at handovers.	Audits of the files will be conducted on a monthly basis by the centre manager along with the team leaders to ensure full recording of the that is work carried out.

5	The registered proprietor must ensure that appropriate governance oversight was in place in the centre to ensure compliance with the National Standards for Children's Residential Centres (HIQA) 2018.	We are putting in place an external monitor (SCL from another centre) to assist with the governance and quality of care provided to the young people in the Centre. The monitor will then report directly to the Director of services.	The monitor and the Director of service will meet with the Centre manager on a 8 weekly basis to review the governance of the centre. The centre manager and the Director will meet every 8 weeks to discuss the general audit
	The centre manager must create a new format for team meetings and include relevant topics for discussion which will add to the overall governance management of the centre.	A new format with structured headings has been implemented by the centre manager from 21st September 2021.	Centre manager will ensure new structure for team meetings will be adhered to weekly, along with oversight from social care team leaders in manager's absence.
	The director of service must ensure that significant events, complaints and concerns are discussed at senior level collectively to account for reviewing and analysing trends that occur.	A subcommittee of the management team and social care leaders will be established to review and analyse trends in the centre and report to the management team.	This will be done on a quarterly basis or following a major incident in one of the centres.
	The director of service and the centre manager must review the risk management framework in place and create a relevant policy and procedure. The details in the pre-admission risk	A new risk management policy along with a framework is being discussed by the policy group and is being further developed and implemented by the centre management and subcommittee.	A subcommittee made up of SCWs and SCLs from the centre and other centres will periodically review the centre risk register and report to the management team.

	assessment must be updated. The staff must undertake training around the risk management framework. The centre manager must establish a centre risk register and a delegation log for tasks/duties undertaken by staff.	The collective risk admission done for pre-admission will be used as a live document going forward, and will be also supported by additional risk assessments. A newly amended risk register is currently being drafted by the organisation policy group and is being implemented by the centre manager. Centre manager will use a delegation system using email to ensure staff are aware of their tasks in the manager's absence. A log will record the dates of these emails.	On-going risk assessments will be reviewed at weekly team meetings. Risk register will be discussed at weekly team meetings, and periodically reviewed by subcommittee. Centre manager will ensure that duties are clearly delegated in his absence.
6	The director of services and centre manager must ensure that vacancies are filled in an appropriate timeframe. The registered proprietor must ensure that staff receive all relevant mandatory training.	The vacancies within the centre have been filled. Extensive mandatory training has been undertaken by the staff team. Centre manager addressed the need for staff members to be aware of deficits in their mandatory training and make these aware to management.	Future recruitment will be prioritised based on the needs of the service. Centre manager along with social care leader responsible for training oversight will periodically audit the training log in conjunction with general auditing.