An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 053

Year: 2018

Alternative Care Inspection and Monitoring Service
Tusla - Child and Family Agency
Units 4/5, Nexus Building, 2nd Floor
Blanchardstown Corporate Park
Ballycoolin
Dublin 15 - D15 CF9K
01 8976857

Registration and Inspection Report

Inspection Year:	**2018**
Name of Organisation:	**Rainbow Community Services Ltd.**
Registered Capacity:	**Four young people**
Dates of Inspection:	**13th & 14th November 2018**
Registration Status:	**31st of March 2019 to 31st of March 2022**
Inspection Team:	**Eileen Woods Sinead Diggin**
Date Report Issued:	**19th February 2019**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions :

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by ongoing demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the ongoing regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in 2007. At the time of this inspection the centre was in their fourth registration and was in year two of the cycle. The centre was registered without attached conditions from the 31st of March 2016 to the 31st March 2019.

The centre's purpose and function was to accommodate four young people of both genders from age sixteen to eighteen years on a short to medium term basis in their own apartment with co-located team supports. Their model of care was described as relationship based with an understanding of attachment and strong core working knowledge of the skills and resilience required for the next stage in the young people's lives.

The inspectors examined standards 1 'purpose and function', 2 'management and staffing' and 5 'planning for children and young people' of the National Standards For Children's Residential Centres (2001). This inspection was unannounced and took place on the 13th and 14th of November 2018.

1.2 Methodology

This report is based on a range of inspection techniques including:

- An examination of inspection questionnaire and related documentation completed by the Manager after the unannounced inspection.

- An examination of the questionnaires completed by:

  a) Director, manager and deputy manager
  b) Seven of the social care staff

- An examination of the centre's files and recording process.
  - care files
  - supervision records
  - handover book
  - training records
  - five personnel files
  - centre registers
  - staff meeting records
  - management meeting records
  - daily logs
  - observation of handover

- Interviews with relevant persons that were deemed by the inspection team as to having a bona fide interest in the operation of the centre including but not exclusively

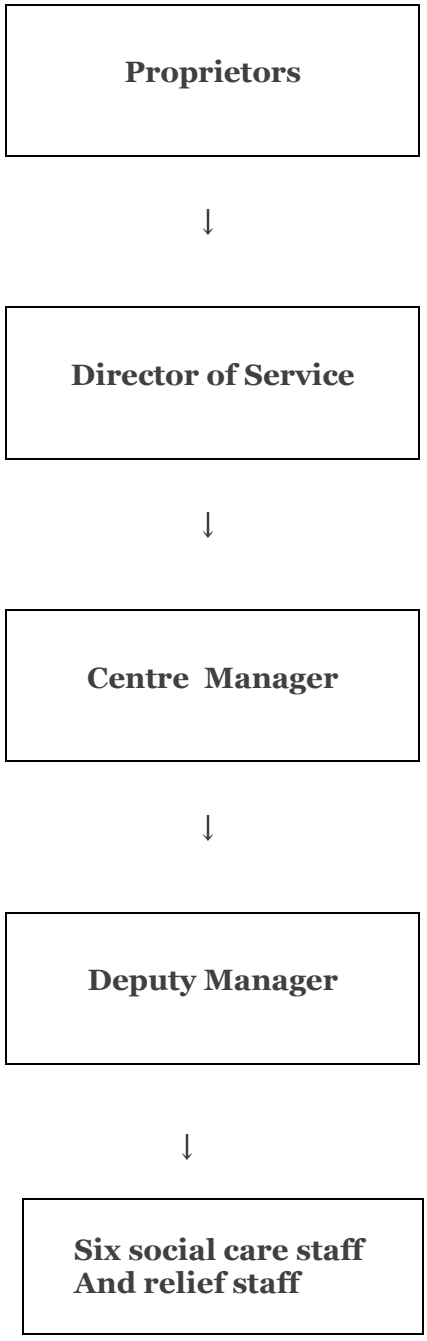
  a) The centre manager
  b) The director of service
  c) Two staff members
  d) The lead inspector

- Observations of care practice routines and the staff/young people's interactions.

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.

1.3 Organisational Structure



2. Findings with regard to registration matters

At the time of this inspection the centre was registered from the 31st of March 2016 to the 31st of March 2019.

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 3rd of January 2019. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a completed action plan (CAPA) on the 16th of January 2019 but this did not contain a full response from the then director who was not available to do so. A more detailed and evidenced response was requested and responded to by the centre management and the new director on dates after the 23rd of January 2019 with a small number of items to follow.

The findings of this report and assessment by the inspection service of the submitted action plans deem the centre to be continuing to operate in adherence to the regulatory frameworks and Standards in line with its registration. The centre had also submitted their application for renewal of registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 053 without attached conditions from the 31st of March 2019 to the 31st of March 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Analysis of Findings

3.2 Management and Staffing

Standard

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.

3.2.1 Practices that met the required standard in full

Management

The manager of this centre has been in post since November 2016 and was experienced in residential care with young people, much of their experience predates the commencement of their academic studies. The manager's role is deemed to be an acting role until such time as they completed their honours degree in social care; they were presently in their final year. The manager was supported by a full time deputy manager who was qualified and experienced also. Both work a full time post aside from college commitments the manager may have. Inspectors found evidence of stable internal management operated by the manager and their deputy manager. The deputy manager and a social care leader had recently completed training in auditing and were implementing rolling audits within the centre. The inspectors found that the managers were focused on the provision of a good service to the young people and were seeking to broaden the skills base of the team to respond to young people's needs. The model in operation at the centre was that of a relationship based approach and the team was structured in a manner to focus daily staff members, called mentors, on getting the young people into a routine with employment, education, appointments, etc.

Both the manager and the deputy manager were aware of the outcomes for individual young people and were seeking to apply the learning from this to their admissions decisions. They did not have formal discharges and outcomes review mechanisms in place and this would be positive for them to develope. Improvements in the pre admission collective risk assessment records were also noted as required and inspectors recommend that these are undertaken by the manager without delay. The manager and the deputy maintained some records reflective of governance but should implement a formal written report mechanism for their records to note the oversight completed. There were improvements necessary in the areas of recording of team meetings and the supervision structure and records also.

The system of governance operated by the director of service was to meet the managers weekly and to document this, the records did capture ongoing business with task and planning generated from it. The director contacted the centre daily and visited the centre regularly. They did not keep a record of meeting the young people and should establish a means of doing so. There was some evidence of their sign off and oversight of documents at the centre. Overall inspectors found that the director should expand the mechanisms through which they oversee the centre and the wider service. There were no audit procedures in place for external review of outcomes or complaints for example along with other areas of service development. There was a yearly review but this was substantially financial in focus. The director had also not completed the management personnel files to the expected standard and these matters must be improved.

Register

The centre maintained a suitable and up to date register at the centre. All admissions and discharges were notified to the Child and Family Agency appropriately.
There was a system in place where duplicated records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

Notification of Significant Events

The centre had a system in place for the notification of significant events. This was operated promptly and accurately to the relevant social work departments and other professionals. The register of significant events was well maintained and reflected that the centre provides care for complex young people who faced a variety of significant challenges in their lives.

Training and development

The manager had advocated for increased access to funding for training in 2017 and 2018 and alongside the deputy manager they had structured a training system with core training and complimentary training completed. The company have their own trainer in their chosen method of crisis management, therapeutic crisis intervention, TCI. The deputy manager had scheduled and maintained a log of all training completed and pending and this was well organised. The team had completed their core training in Children First, fire safety, first aid and TCI. They had also completed additional training in anti bullying, self harm, drugs and alcohol.
Inspectors found the training was responsive to and relevant to the needs of the young people. High numbers of staff attended the training booked and a well

maintained resource folder of handouts and information gathered to inform practice was available to the team.
An anomaly was found by inspectors in the area of child protection training when it was established that the management stated that they were not aware that all staff must complete the national e-learning programme on Children First. This was commenced immediately following the inspection and all e-learning certificates have been completed.

Administrative files

The records at the centre were easily accessible to inspectors upon arrival for this unannounced inspection. There was evidence of oversight by the deputy manager daily and the manager weekly on most records. It was difficult to discern how many of the records the director audits. One social care leader and the deputy manager completed training in auditing in a social care context and were at the time of this visit initiating a system for formal quality assurance auditing of the files. The team had completed training in report writing in 2018.
The management discussed petty cash on a weekly basis and this appeared to be suitable to the needs of the project. There was a well structured system for young people's finances and there were extra, discretionary monies given to young people.

3.2.2 Practices that met the required standard in some respect only

Staffing

The staffing complement is six and a half staff and a manager and deputy manager. The timings of the roster were flexible depending on a young person's needs, for example if a young person is at a school a distance away a staff member would start earlier to ensure they were driven to the school. Inspectors found that there were sixteen active staff files aside from the managers, it seems wise to expand the permanent staff and to minimise numbers of different staff coming through the centre. There was three staff throughout the day and two managers Monday to Friday. One person sleeps over and one waking night works each night. There were different roles on the team with mentors being directly involved in the daily structured programme for the young people and spending time with them in their flats, the young people also had a key worker separate to the mentors. The team presented as knowledgeable and committed to the young people and aware of the special nature of this semi independent project. All staff were involved in life skills development and the provision of support to the young people. Inspectors found that an induction pack was in place with a focus on paperwork and policy implementation. Training had also been organised without delay for new staff.

Inspectors reviewed a sample of five personnel files in total, the managers oversaw the personnel files for the core team and the director oversaw the personnel files for the two managers. The personnel files managed at the centre internally had been audited twice by the managers with a clear intent that they meet the national guidelines for vetting. Whilst inspectors found that these had been organised with good intent that the system of sourcing references resulted in there being no reliable evidence of who or what organisation the reference was definitely from and this must be rectified. The two manager's files maintained by the director required significant improvement and immediate action in the areas of the CV's matching to references and to start dates. The Garda clearance for one requires renewal and a copy of a UK clearance did not display the date. There were only two of the required three references on a file and the same issue with the proof of origin of the references pertained. There were no qualifications on file and therefore not verified either.

Supervision and support

The centres supervision policy states that sessions should take place within a six week time frame and this was found to be taking place. The manager and deputy manager share the supervision of the core team and the social care leader supervises the two night staff. The manager stated that they oversee the supervision provided by the deputy and the social care leader. All three have trained in the provision of supervision and stated that from this recent training they have recognised the need to enhance their supervision format. This was under development and nearing approval for implementation at the time of the inspection. Inspectors found that the format was limiting and did not reflect a holistic picture of the work, the development or the staff support elements. There were few agendas and little assignment of task or review of actions. There were no supervision contracts and no supervision trackers in place.

The records of supervision were not reflective of the overall team development inspectors found elsewhere at the centre. The records were stronger in content when dealing with those in a designated mentor role but skills and knowledge should be strengthened equally across the team. The director did seek feedback from the managers about the supervision delivered but there was no evidence that they audited these directly from time to time. Inspectors found that supervision was valued and was organised at the centre but that it needed improved formats and structures around it to improve it.

The staff in their responses to inspectors stated that they are well supported in their roles, that the managers shared an on call system and will come into the centre if the nature of the incident was serious for example, an assault. There was no record of a

formal employee assistance programme being advertised as available to staff and this should be rectified.

There were weekly or fortnightly team meetings and one young person and their plans were specifically reviewed in detail in rotation. Inspectors reviewed the minutes of these and found that the team need to assign a chairperson and minute taker, that a structured agenda should be in place and that meetings should start with a routine review of actions from the previous meeting. Aside from the structural aspects of the team meetings it was clear from the minutes maintained that the young people and their plans were reviewed and that the team were particularly alert to the young people's emotional state.

3.2.3 Practices that did not meet the required standard

None identified

3.2.4 Regulation Based Requirements

The Child and Family Agency have met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV, Article 21, Register.***

The centre have met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 5, Care Practices and Operational Policies
-Part III, Article 6, Paragraph 2, Change of Person in Charge
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)
-Part III, Article 16, Notification of Significant Events.

Required Action

- The director and the managers must correct any outstanding deficits in vetting and implement safe vetting procedures for the personnel files that bring them into compliance with the Department of Health national guidelines and best practice in this area.
- The director must review the range of measures through which they implement governance and oversight and augment these in the identified areas.
- The management must improve the quality and content of supervision and team meeting records.

3.5 Planning for Children and Young People

Standard

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The 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.

3.5.1 Practices that met the required standard in full

Suitable placements and admissions

This service was for sixteen to eighteen year olds and accommodation provided in individual flats co-located with a staff office adjacent to it. The manager stated that the criteria for referral does not exclude complex young people for whom other models of care have not met their needs but that a young person has to show some evidence of an ability to display life skills and manage themselves. They also have to actively want this type of project with the separate living arrangements.

The manager stated that their experience had established that those with areas of risk in their lives had demonstrated an ability to prosper and do well within the project. Therefore the decision on suitability was individualised, determined by management and guided by but not limited by risk assessment tools. There was a standardised collective risk assessment completed in conjunction with the referring social worker. The existing social workers are also consulted and once these had been completed the centre do their own risk planning. Inspectors reviewed a sample of four pre admission collective risk assessments and found that they were not truly collective in nature as they considered the young people singly and not in direct relation to the resident group, the risks were listed but it was not listed how these would be addressed and managed within the centre programme.

The manager stated that the ideal length of time to work with young people would be from sixteen but that in general the age range upon referral has clustered around the age seventeen. There had been ten admissions since September 2017, and all four apartments were occupied at the time of the inspection, of these young people the main group were aged seventeen or close to seventeen.
The manager outlined how their admissions procedures seek to get enough information to assist in safeguarding all the young people but that there has been

impact of young people on each other which had been managed by the team. There was evidence on file that there had been discussions with the young people about the reasons for the placements there and transitions had been provided wherever possible.

Statutory care planning and review

All four young people had care plans and statutory reviews completed where applicable. Copies of these were available on file at the centre. There was evidence of young people attending these meetings where they wished to and their views were well recorded on the plans.

Placement plans were developed promptly from the outset of the placements and were reviewed regularly thereafter. The young people could be seen by inspectors to have taken part in the development of the goals and plans in place. The placement plans were evaluated and the suitability to the project was reassessed on a monthly basis. There were also reports completed monthly which took an overview of significant events as well as the programme of care and how one impacted the other.

Contact with families

There was strong evidence of the inclusion of family in the day to day lives of the young people at the centre. It was clear that all staff carried this ethos through and sought, where safe, to inform and include family members in daily life. Family and extended family along with significant people in the young people's lives had been invited to visit the centre.

Emotional and specialist support

The managers assigned a key worker to each young person and there were two mentors who alternated daily to give specific support to young people. Inspectors found though that given the small size of the team all staff had an influential role with the young people and completed implementation of the semi independence/life skills programme. The key working and mentor work on file was found to be relationship based as well as practical and a mix of planned and unplanned/opportunity led sessions and events designed to engage the young people. The team were found to keep a record of any observations they had or comments made by a young person related to mood and emotional state. There were plans in place to respond to the specific emotional needs of the young people. There were risk assessment and management plans that addressed low mood, suicidal ideation and self harm. There were details on file of the suitable external professionals available to the young people and the team advocate for additional psychological supports for the young people if needed. The team members are expected to engage with young people inside their

apartment to combat feelings of isolation settling in. This is a challenge for young people in this type of setting.

Preparation for leaving care

Inspectors found that the purpose of the centre was carried through cohesively from admission to placement plans and through to the life skills folder system in place. Life skills assessments had been done with the young people and signed by them. All of the young people had life skills folders, these showed that the life skills programme was holistic and supported from the outset. The independent living skills folders contained records of individual work across fourteen areas of life skills work. There was significant evidence of efforts to engage with the young people and to help them engage in education, training, and interests.

Discharges

Ten young people had moved into the centre since September 2017 and four were residing there at the time of the inspection. Of the six who left prior to this inspection five of them left under the age of eighteen. Two went home, one to secure care, one with their parents consent and a young person was discharged in an emergency following a serious assault committed.

There was some evidence of a discussion after discharges but no formal review mechanism to ensure learning is integrated into future practice and it would be positive to see this type of process implemented at the centre.

Aftercare

There was one young person over eighteen at the centre who had an aftercare plan and was pending the assignment of an aftercare worker, a social work team leader was managing the case until one became available. This was due to waiting lists in Dublin mid Leinster.

There were two young people aged seventeen or soon to be and of these the older one had been assigned an aftercare worker and a plan was pending. The second young person had a recent child in care review and once seventeen an application for an aftercare worker and plan should be completed.

The fourth young person was sixteen and has just had an aftercare worker assigned. The actions in line with national policy varied area to area depending on local resources and highlight that young people nationally receive an uneven service as they approach eighteen. Therefore the young people in this centre were reliant on the care and support provided by the team to provide stability in the lead up to leaving care in several instances.

Children's case and care records

The young people's files contained copies of their birth certificates and other essential documents required. The team worked with the young people to ensure they have completed practical tasks related to documentation such as passports, forms of identification and banking.

3.5.2 Practices that met the required standard in some respect only

None identified

3.5.3 Practices that did not meet the required standard

None identified

3.5.4 Regulation Based Requirements

The Child and Family Agency have met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995***

-Part IV, Article 23, Paragraphs 1and2, Care Plans

-Part IV, Article 23, paragraphs 3and4, Consultation Re: Care Plan

-Part V, Article 25and26, Care Plan Reviews

-Part IV, Article 24, Visitation by Authorised Persons

-Part IV, Article 22, Case Files.

The centre have met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) 1996***

-Part III, Article 17, Records

-Part III, Article 9, Access Arrangements

-Part III, Article 10, Health Care (Specialist service provision).

3.7 Safeguarding and Child Protection

Standard

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.

3.7.1 Practices that met the required standard in full

None identified

3.7.2 Practices that met the required standard in some respect only

The centre had policies and procedures designed to support the safe care of young people. The staff had received training in child protection and in complementary areas related to young people's well being. There were ongoing and dynamic risk assessments on the files and there was some review of significant events to inform safer care. As the centre is constructed in a manner where the apartments are adjacent to the staff area there is a night waking staff and CCTV cameras in common areas. There were also rules about being in each other's apartments as well as a security gate to gain access to the property.

Young people are informed of their rights in a young people's booklet and by follow up with staff, a system of warnings was used if the risks ran too high and were not mitigated by intervention. An assault whether on a young person or a staff member can result in discharge. This has occurred on one occasion in 2018 with the director trying to ensure support for the young person in this instance due to the emergency nature of the discharge. This event was investigated internally after the assault and learning integrated into practice to avert future clashes between young people that might threaten placements.

There were procedures in place for lone working and inspectors found that staff had good working knowledge of these.

The personnel files did not meet the required guidelines for safe and competent vetting and these must be corrected.

Child Protection

Standard

There are systems in place to protect young people from abuse. Staff are aware of and implement practices which are designed to protect young people in care.

Inspectors found that the team had been provided with training in child protection in 2018 through a private training provider. The manager had registered the centre to the appropriate online reporting mechanism and the director of service had been identified as the relevant person. The centre's child protection policy had not yet been updated to reflect these changes. The management had not however ensured that they and the team had completed the compulsory national e-training in Children First and did not have a Child Safeguarding Statement as required by the Children First 2015 Act. The managers and director acknowledged this deficit and completed a Child Safeguarding Statement without delay, this was submitted to the child

safeguarding statement compliance unit who verified the final document as "deemed compliant" on the 6th December 2018.
The manager informed inspectors that all staff have now completed the e-learning in Children First and that certificates for same were now on file at the centre. There were no pending or open child protection matters on file at the centre at the time of this inspection.

3.7.3 Practices that did not meet the required standard

None identified

Required Action

- The management must update the centres child protection policy to reflect the legislative and procedural changes.
- The management must ensure that the policy on vetting is updated to include the accurate standard of vetting required.

4. Action Plan

Standard	Issue Requiring Action	Response with Time Scales	Corrective and Preventive Strategies To Ensure Issues Do Not Arise Again
3.2	The director and the managers must correct any outstanding deficits in vetting and implement safe vetting procedures for the personnel files that bring them into compliance with the Department of Health national guidelines and best practice in this area.	All new staff members joining the centre will be appropriately vetted in line with e-vetting protocols prior to commencement of employment. Records of Garda vetting and dates of inception of employment will be retained in personnel files. Going forward all staff will be re-vetted every two years, will have three verified references on file and curriculum vitae dates will be correct. All qualifications to be verified.	A vetting rota has been placed in the manager's office. There will also be a record kept on the front of all personal files. All staff to be re-vetted every two years. References to verified by company stamp or headed paper before commencing employment.
	The director must review the range of measures through which they implement governance and oversight and augment these in the identified areas.	The director will visit the centre weekly and will be in phone contact regularly with the centre manager and the staff team. The director will attend staff meetings as they occur (currently every fortnight). Systems will be put in place to review the range of measures to implement governance oversight including the supervision of both manager and deputy	The director will implement the stated actions and will maintain these in an evidenced manner.

		manager on a monthly basis. SEN'S to be sent to director for review. The manager emails monthly reports to the director, such as supervision, annual leave, petty cash and updated placement plans / young people's monthly's. The director of services and the centre manager will conduct a bi-yearly appraisal with all care staff to support monitor and develop care practices. The director of services and the centre manager will carry out an internal audit every 3 months. The manager and team leaders to meet to assign individual tasks and roles to ensure that internal systems are robust. Management and team leaders will meet every 8 weeks to ensure consistency and continuity of internal systems.	

	The management must improve the quality and content of supervision and team meeting records.	The management team have implemented a new format for supervision. This includes a new supervision contract. This system is now in place and all the team have started to receive supervision from this rather than the old format that was being used. Team meeting minutes will be typed up on the day of the meeting and added to the team meeting folder. We feel that this will help improve the quality of our minutes. Designated staff members will take the minutes going forward as to ensure the quality of minutes taken.	The director will oversee the roll out of improvements in delivery and content of supervision. Team meeting minutes to be reviewed by deputy manager monthly with files checks.
3.7	The management must update the centre's child protection policy to reflect the legislative and procedural changes. The management must ensure that the policy on vetting is updated to include the accurate standard of vetting required.	Our child protection policy has been updated to reflect recent legislative changes. We have added our child safeguarding statement to our child protection policy. The vetting policy has been updated to reflect how staff are vetted. This is in compliance with the Department of Health national guidelines. All staff to have three	Policies to be reviewed every twelve weeks or when needed. All staff to be re-vetted every two years.

		verified references on file. Curriculum vitae dates to match and be verified. All qualifications to be verified.	