An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency

# Registration and Inspection Service

## Children's Residential Centre

**Centre ID number: 103**

**Year: 2018**

**Lead inspector: Linda Mc Guinness**


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## Registration and Inspection Report

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| **Inspection Year:** | **2018** |
| **Name of Organisation:** | **Daffodil Care Services** |
| **Registered Capacity:** | **Six young people** |
| **Dates of Inspection:** | **31st of January, 1st and 22nd of February 2018** |
| **Registration Status:** | **Registered from 3rd of March 2018 to the 3rd of March 2021** |
| **Inspection Team:** | **Linda Mc Guinness and Michael Mc Guigan** |
| **Date Report Issued:** | **21st May 2018** |

# Contents

1. **Foreword** 4

1.1 Centre Description
1.2 Methodology
1.3 Organisational Structure

2. **Findings with regard to Registration Matters** 10

3. **Analysis of Findings** 11

3.1 Purpose and Function
3.2 Management and Staffing
3.5 Planning for Children and Young People
3.6 Care of Young People

4. **Action Plan** 24

# 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 2015. At the time of this inspection the centre were in their first registration and were in year three of the cycle. The centre was registered without conditions from the 3rd of March 2015 to the 3rd of March 2018.

The center's purpose and function was to provide short to medium term semi-independent living support for up to six young people of mixed gender between the ages of sixteen to nineteen years. The purpose was to prepare young people for leaving care, independent living and adulthood. Their model of care was described as a therapeutic support model with an emphasis on positive interventions. The centre operates under the STEM (Systemic Therapeutic Engagement Model) model of care.

The inspectors examined standards 2 'Management and staffing' and standard 6 'Care of Young People'of the National Standards For Children's Residential Centres (2001). This inspection was announced and took place on the 31st of January , 1st and 22nd of February 2018. Inspectors also reviewed implementation of recommendations from a 2017 monitoring report and in doing so commented upon standard 1 'purpose and function' and aspects of standard 5 'planning for young people' .

## 1.2 Methodology

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

- An examination of pre-inspection questionnaire and related documentation completed by the directors of services.

- An examination of the questionnaires completed by:

a) The social care manager

b) All the staff team

- Questionnaires were sent to the social worker(s) with responsibility for two young people residing in the centre. These had not been returned by time of writing this report but inspectors met with social workers in person. The third young person who was over 18 years of age had no allocated social worker.

- An examination of the centre's files and recording process including;
    - The care file for one young person under 18 years,
    - sample of supervision records,
    - sample of personnel files
    - training audits,
    - handover book,
    - maintenance log,
    - management meetings,
    - team minute meetings,
    - STEM meetings
    - quality assurance reports,
    - young people's log book,
    - centre registers
    - young person's booklet

- 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 social care manager
    b) The regional manager
    c) The assistant director of service

d) Three of the staff team
e) The lead inspector for this organisation
f) The social workers and social work team leader for one of the young people
g) The social worker for another young person

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

- Review of implementation of previous recommendations from inspection and monitoring audits

- Attended the senior management and SERG meetings.

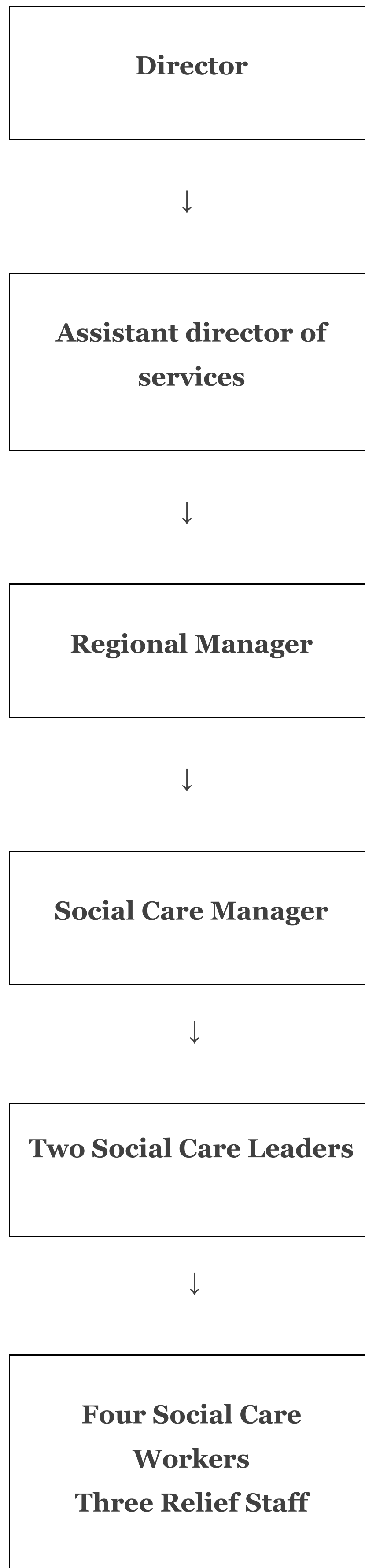
- Attended handover meeting

The young people in the centre were provided with opportunities to meet with inspectors however chose not to do so. The two young people over 18 years chose not to allow inspectors to view their care files.

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

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 6th of March 2018. 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 satisfactory completed action plan (CAPA) on the 16th of March and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the 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: 103 without conditions from the 3rd of March 2010 to the 3rd of March 2021 pursuant to Part VIII, 1991 Child Care Act.

# 3. Analysis of Findings

## 3.1 Purpose and Function

***Standard***

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

### 3.1.1 Practices that met the required standard in full

There was a comprehensive statement of purpose and function which was in keeping with the requirements of the National Standards for Children's Residential centres 2001. This document outlined the key policies in place and described in detail the service it intended to provide for young people. It is reviewed annually or as required.

Previous recent inspection and monitoring reports had recommended that all placements must be n line with the purpose and function, and that pre-admission risk assessments take place to determine the suitability of placement to each young person's identified needs. Inspectors found that centre management had reviewed a number of placements which had not been successful and that learning had been taken from these. Inspectors found that there had been some improvements in respect of this issue and that consultation with all professionals and the pre admission risk assessment process was evident on files of young people. These documents included information about presenting behaviours, description of risk, the frequency of behaviours and the likely impact on both themselves and the already resident young people. Centre management informed inspectors that they had refused some referrals to the centre as they did not pass this risk assessment process and it was determined that the placement would not be suitable. Inspectors recommend continued diligence in this regard to ensure suitable placements and minimising the risk of unplanned discharges.

Some staff members in interview or through feedback questionnaires felt that the age of referral to the service would be better set at seventeen years of age instead of sixteen to ensure that they were more ready for preparation for leaving the care system. The assistant director of service and regional manager informed inspectors that the expectations of these young people are adjusted accordingly and they are provided with an individual plan which increases staff support if required. The statement of purpose and function stated that age related preparation for care would

be provided and this was also provided based on a holistic needs assessment. The statement of purpose and function was available to young people and their families.

### 3.1.2 Practices that met the required standard in some respect only

None identified

### 3.1.3 Practices that did not meet the required standard

None identified

### 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

**Register**

During this inspection, the centre register was reviewed and found to be complete and in line with regulatory requirements and the National Standards for Children's Residential Centres, 2001. The register contained details of young people, their admission dates and information on their parents and social workers. 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 policies and procedures in place governing the prompt notification of significant events. The lead inspector for this organisation and all social workers interviewed by inspectors confirmed that reports were received in a timely manner. The majority of notifications for this centre were relating to absences of the young people from the centre. The register contained an entry and reference numbers, the young person's name, details of the event, the staff members involved if necessary. Review by centre management was also evident on this register. Information pertaining to review of significant events is reported upon in the 'behaviour management' section of this report.

**Staffing**

Inspectors found that the centre had adequate levels of staff to fulfil its purpose and function. Inspectors reviewed a sample of personnel files and noted that each staff member had up-to-date Garda vetting and three verified references on file as required. Qualifications were held on file and were verified in line with the department of health circular 09/11/94. There was evidence that all staff received formal induction to include policies and procedures, training and 'shadowing' experienced staff at the outset of employment.

Four new staff members had commenced employment in this centre the eight months prior to this inspection. This was quite a high number in such a short period however interviews showed that this had been managed well.

Inspectors reviewed a sample of three exit interviews for staff members who had left the organisation to move to employment elsewhere. All three staff cited pay, terms and conditions (such as sick leave and maternity leave) as a reason for moving on and an area that the organisation should address. It is important to note that each staff member complemented the care to young people and the support they received while working there and would consider returning if circumstances were different. While management meeting minutes reflected that exit interviews were discussed it was not evident that these exit interviews had fed into a strategy of recruitment and retention of staff. This should be addressed at senior management level as a consistent high turnover of staff is not without impact on consistency of care to young people.

Review of key-working records and interviews with staff evidenced that staff had an ability to relate to and communicate effectively with young people; although the nature of semi-independent living meant that some young people in the centre at the time of inspection had chosen not to engage in a meaningful way despite the efforts of the team. Both social workers interviewed by inspectors were complimentary about the work that individual members of the team had put in place to try to build relationships and engage the young people.

**Administrative files**

Inspectors found that the administrative files were well maintained and facilitated effective planning. Data protection legislation was discussed and planned for in senior management meetings. There was evidence that centre registers and administrative files had been periodically reviewed by the centre manager regional manager and directors of service. Annual audits by the quality assurance team picked up deficits as required and that review of centre records showed that some of these

had been rectified with others on-going. There were effective financial management systems and records in place.

### 3.2.2 Practices that met the required standard in some respect only

**Management**

There had been a recent change of management in the centre with the previous manager leaving their post in late 2017. A new social care manager was not appointed until a number of days before this inspection. There had been arrangements in place to have the post covered in an acting capacity in the interim period while recruitment was taking place. Inspectors found that the assistant director of service was present in the centre and provided advice, support and guidance during this period. From review of documents and interviews inspectors found that day to day operations of the centre were unaffected by changes in management and that service to young people remained consistent. There were gaps in other aspects of operations such as the provision of supervision which is detailed under the relevant section of this report.

The newly appointed manager had the required qualifications and experience, was appropriately vetted and inducted into the post. They were able to provide inspectors with a robust description of governance processes and how they intended to ensure that there were appropriate practices in place. These included oversight of records, the IT cloud based system, on call arrangements, induction processes, reviews of young people's plans, supervision, team and management meetings and staff training.

Inspectors reviewed records of the senior management meetings which were scheduled to take place on a monthly basis. There were 11 records for 2017 and the meetings were generally attended by social care managers, regional managers, directors and quality assurance personnel. The records evidenced a general overview of the operations in each centre, discussions in respect of issues such as staffing, training, on-call, maintenance, audits, supervision of staff, risk registers and standard operating procedures. Placement plan templates, exit interviews, data protection, and regional monitoring tools were also discussed. These meetings showed a positive focus on service development and pointed to good governance in general.

Inspectors however did note that the records of these meetings followed a set template which included a 'case management' section and 'utility reports'. These

sections were not completed in the majority of the monthly records and centre management must ensure that the template is used as intended or amended to suit requirements. There was no evidence that this issue was picked up by management within the organisation.

Another example of this type of deficit was in the weekly governance reports where there was a section to look at the STEM focus for the team and supervision however many of these sections in the reports reviewed by inspectors were not completed and this did not seem to have been addressed by the regional manager.

The regional manager was responsible for four centres within the organisation and described their duties to include oversight of the records through the IT system, daily contact with centres and attendance at team and management meetings. They also had oversight of the complaints and financial management systems. The regional manager informed inspectors that they had a 'six month auditing plan' for each of the centres which was dependent on what was happening at that time. Through interview with other senior management and social care staff it was evident that the regional manager had a presence in the centres and that there was regular communication with centre management. Their signature was evident upon reviewing care files and other documents. What was not clear was how they audited the care practices, compliance with regulations and standards and if they had identified remedial actions where deficits were noted. There were no previous records of formal audit processes available to inspectors. The regional manager must have transparent process and a clear evidence chain to record their oversight and implementation of recommended actions.

There were monthly regional management meetings in place where there was a focus on, and analysis of, application of the STEM model of care into young people's plans and across the centres. One inspector attended one of these meetings and found that there was detailed child focused discussion which was reflective in nature. They reviewed the outcomes of the previous meeting and determined an appropriate focus for the next month. Resource material in support of this and provision for training for staff was made available if required.

An external monitoring folder was provided to inspectors. There were quality assurance managers in post for the organisation. A 'two step' audit process takes place annually which includes a self-audit by the social care manager and a follow up formal audit process by a quality assurance manager. These audits were clearer in terms of compliance or non-compliance with regulations and standards and a clear

action plan was provided at the conclusion of the process. Inspectors noted that outcomes were required to be improved under team meetings, health and safety, registers, supervision, admissions, planning, medical and practice. There are weekly governance reports in place which are completed by the social care managers. It was evident within these reports that follow up to the annual audit reports and action plans were referenced.

There was also a system in place to allow for unannounced and 'themed' audits of each centre. The quality assurance managers met regularly with the senior management team. While this auditing system was clear, outcome focused and showed tracking of actions they were only on an annual basis and review of management meetings showed that on occasion these had been postponed if another centre took priority. Therefore an efficient auditing system to include process, auditing tools/records, and action plans should be evident by the regional manager for responsibility for the centre. These should be regular and take place between annual audits.

**Supervision and support**

There was a supervision policy in place however inspectors noted that sessions were not always occurring in line with policy. A new supervision tracker had been put in place and was included on the weekly governance audit report although inspectors noted that supervision was not noted on seven of these reports between 17/09/17 and 05/11/17. The assistance director of service acknowledged that supervision had fallen behind and there was a strategy in place with the appointment of the new manager to ensure compliance with policy.

From a review of a sample of supervisions inspectors found that some records were noted as 'supplementary supervision'. There was a 'tick box section to record the type and content of the discussion. Examples of these boxes included training, child protection, practice, feedback, health and safety, debriefing, performance, key-working, placement planning and centre duties amongst others. While the focus of the discussion was clear there was very limited narrative on some of these records and it was clear they were not formal supervision as required. There was a space for decisions to be recorded separately.

Other records were noted as formal supervision and these included discussion headings of performance management, placement planning, learning and development, support and review of significant events. This form was functional and allowed for discussions and records of decisions and actions required. Inspectors

found that much of the actions from supervision processes were focused on practical and organisational matters such as clarity of role, paperwork etc. Some of the record just show that 'case management continues' and details of who is key-working but not how staff are to attend to needs or tasks identified in the individual placement plans. There was evidence that placement planning formed part of the managers' meetings, and inspectors recommend that improvements are made in how this is reflected clearly in supervision as required by national standards.

**Training and development**
There was an on-going staff development and training programme and training needs were discussed at supervision and at team and management meetings. Inspectors note that there were some gaps in the provision of mandatory behaviour management training and this was explained by centre management that they provide training on a 'cycle' so that they wait until there is a quorum of people to be trained in a certain module. This is not an ideal situation and requires some focus by centre management to ensure that all staff are fully trained. There was no evidence that there was a risk assessment or plan to manage risks associated with staff working in the centre who had not for example yet received the mandatory training in Child First – National Guidance for the Protection and Welfare of Children or in the recognised behaviour management training programme. All staff had not yet completed the mandatory on line update for the revised version of Children First 2017. Some staff members were scheduled to attend first aid training and designated behaviour management training in early 2018.

There was a training audit in place and additional training provided to the staff included STEM, supervision, self-harm, alcohol and drug awareness, administration of medication amongst others.

### 3.2.3 Practices that did not meet the required standard
None identified

### 3.2.4 Regulation Based Requirements
The Child and Family Agency 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 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 Actions**

- The regional manager must have transparent processes and a clear evidence chain to record their oversight, direction and implementation of recommendations from audits.
- Centre management must ensure that meeting record templates are used as intended.
- Centre management must ensure that all staff supervision takes place in line with policy.
- Centre management must ensure that there are improvements in how tasks relating to goals of placement plans are discussed and recorded clearly in supervision as required by national standards.
- Centre management must ensure that all mandatory training takes place at the earliest opportunity.

### 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
All criteria not assessed

#### 3.5.2 Practices that met the required standard in some respect only
All criteria not assessed

**Statutory care planning and review**

Not all young people in this centre had an allocated social worker or care plans and child in care review meetings as some had turned 18 years of age and had only an allocated aftercare worker. There were aftercare plans in place. They did however, all have a placement plan in support of the goals of the placement and in line with the purpose and function to prepare young people for aftercare and independent living. Inspectors found that the placement plan template was comprehensive and the headings and actions facilitated effective planning. The assistant director of service said they were also 'piloting' another template in some of the other services to see if further improvements could be made.

Overall, inspectors found that placement planning had improved since recommendations made in previous inspection and monitoring reports. There could however, be further improvements made in how placement planning is linked to the STEM model of care and how identified goals and actions in respect of aftercare preparation could better be evidenced in the plans. Each social worker interviewed during the inspection process confirmed that there was excellent communication and consultation with the management and team in respect of planning for young people. They spoke highly of the efforts of the team to build relationships and implement plans with very complex young people who were resistant to engage. A number of strategy meetings had taken place to make efforts to protect the placements of young people who were either continually absent from the centre or engaging in risk taking and criminal behaviour.

### 3.5.3 Practices that did not meet the required standard

None identified

### 3.5.4 Regulation Based Requirements

The Child and Family Agency 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 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).***

**Required Actions**

- Centre management must ensure there are further improvements made in how placement planning is linked to the STEM model of care and how identified goals and actions in respect of aftercare preparation are better evidenced in these plans.

### 3.6 Care of Young People

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

### 3.6.1 Practices that met the required standard in full

**Individual care in group living**
There was evidence that young people were respected and treated individually by the staff team. Each young person had a plan specific to their own assessed individual needs. The semi-independent nature of the service lent itself well to young people being encouraged to make decisions for themselves and be involved in their planning. From a review of care files and interviews with staff inspectors could see that key-working and opportunity-led individual work focused on encouraging young people to develop their interests and hobbies. They were supported to join local groups and clubs and maintain positive friendships outside the centre. The placement plan reviewed in respect of one young person showed that the team were assisting and helping them to prepare them for independent living with a focus on tasks such as education, employment, creating a c.v., sexual health education, opening a bank account, and maintaining a healthy diet.

**Provision of food and cooking facilities**

Young people were supported in line with the purpose and function for the centre to shop for and prepare nutritious food. Placement plans had a focus on healthy eating. There was a staple larder in the centre where young people could access certain items to help them prepare meals.

**Race, culture, religion, gender and disability**

There was a policy on diversity and anti-discrimination which all staff members were aware of. There was evidence that the staff team made every effort to learn about a young person's culture and help them identify with their own heritage and community. There were no young people with a disability in the centre however acceptance and tolerance of all differences was a feature of the policy and is built into placement plans if appropriate.

**Restraint**

There was a policy in respect of physical restraint although this was not a feature for any young people living in the centre. Any such interventions would be notified to all relevant persons as a significant event and entered on to the register. Some staff had yet to receive up to date training in the stated behaviour model of care.

**Absence without authority**

As mentioned previously most of the significant events being notified for this centre were related to young people being absent and at risk, or missing in care if they were under 18 years of age and their whereabouts unknown. Each young person had an individual absence management plan which inspectors noted was not in line with the Joint National Protocol for Children Missing from Care. Any other information currently held on the plan could form part of the risk assessments and behaviour support plans mentioned above.

### 3.6.2 Practices that met the required standard in some respect only

**Managing behaviour**

There were a number of policies governing the management of behaviour and all young people were given clear expectations about behaviours and responsibilities at the outset of their placement. This was balanced by the provision of clear information detailing their rights whilst living in the centre.

The centre operates from the STEM model of care. One aspect of this approach is the application of a recognised model of behaviour management and training in this programme is mandatory. Inspectors found that there was a delay in some staff receiving this training while they waited for a group to be trained together. This model of behaviour management called for the development of an individual crisis management plan (ICMP) for each young person, the intention being to support them to manage behaviour which may result in them moving away from baseline behaviour and becoming a danger to themselves or others. Inspectors note that these plans while very detailed, overstepped the purpose of an ICMP and were more along the lines of a behaviour support plan to include strategies for managing issues such as risk taking behaviour. These would be useful documents in their own right but must not be confused with an ICMP. Each ICMP should be analysed and amended as required in respect of debriefing, post crisis response and significant event review processes in line with the stated behaviour management approach. Centre management must ensure that each plan fulfils its primary function one being to support staff both with strategies to manage challenging behaviour in the moment, and the other to manage identified behaviours which are harmful to the young person. Each young person had a 'practice guidance' document to support all aspects of planning.

There was a significant event review group (SERG) in place which took place each month. At the time of onsite inspection, from review of the records and interviews with staff it was not clear that this forum was used to review staff interventions, staff application of young people's plans (such as the ICMP) and the outcomes achieved. The antecedents, interventions and outcomes should be routinely analysed to inform any learning for an individual staff member, the staff team or for learning which could be applied across the organisation. The feedback loop to staff members was not clear from the records or from discussions with staff members.

Subsequently, an inspector attended one such meeting and found that there was a good overview of events which had taken place in each centre. Each centre in attendance also presented one event and follow up work for analysis. A good awareness of the emotional needs of young people was evident and the staff members sought to put young people's risk taking and challenging behaviours into context. There was also a good focus on what was going well for young people and a focus on interventions which had been successful. The desire to see positive outcomes and try various interventions was clear. The centre management had taken account of initial feedback from inspectors and changes to the format of the meeting was suggested to ensure that there would be a clear feedback process to the individual staff teams.

There was a sanctions register in place which recorded details of all sanctions given to young people. This register contained details of the date, the young person's name, the type of sanction and the reason for it. The date of conclusion and the signature of the social care manager was also recorded on this log. Since 28/06/17 there have been 13 entries to the register. Seven of these entries related to young people smoking illegal drugs on the premises. There was evidence that young people were informed that should this continue then An Garda Síochána would be called to the centre which was the case on these seven entries. Inspectors noted that there was evidence of oversight of the register and notes on the entries as to how effective they had been in supporting a change in behaviour.

There was evidence of debriefing and support for staff following difficult or challenging behaviour.

### 3.6.3 Practices that did not meet the required standard

None identified

### 3.6.4 Regulation Based Requirements

The centre met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
***-Part III, Article 11, Religion***
***-Part III, Article 12, Provision of Food***
***-Part III, Article 16, Notifications of Physical Restraint as Significant Event.***

**Required Actions**

- Centre management must ensure that individual crisis management plans are separate to risk management and behaviour support plans and staff are clear about the differences.
- Centre management must ensure that there is a definite feedback loop from the SERG to the staff team, that all staff understand the process and that this is evident in the records.

## 4. Action Plan

| Standard | Issues Requiring Action | Response with time scales | Corrective and Preventative Strategies To Ensure Issues Do Not Arise Again |
|---|---|---|---|
| 3.2 | The regional manager must have transparent process and a clear evidence chain to record their oversight, direction and implementation of recommended actions.<br><br>Centre management must ensure that meeting record templates are used as intended. | Regional Manager will provide evidenced oversight on all documentation leaving the centre including SEN's, Weekly Governance Reports, Keyworker Weekly, Monthly Placement Plan and updated IAMP, ICMP and Practice Guidelines reports. Confirmation/ feedback / actions following review of same to be submitted to Social Care Manager for completion.<br><br>SCM has reviewed template and all sections are to be completed. | Recommended actions and implementation of same to be set as a standing item in SCM's supervision with the Regional Manager. In addition, the Regional Manager will chair the Monthly Regional Managers Meeting which includes the SERG, STEM meeting and Regional Managers Meeting.<br><br>Template reviewed and SCM to ensure all sections are completed. |

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| | Centre management must ensure that all staff supervision takes place in line with policy | Social care manager and social care leaders have developed supervision schedule in line with policy – 14.03.18, Regional Manager will oversee the implementation and quality of supervision in line with policy | Supervision schedule in place for both fulltime and relief staff.<br><br>Social care manager and Social care leaders are to ensure all tasks are recorded on supervision record and followed up at next supervision meeting. |
| | Centre management must ensure that there are further improvements in how tasks relating to goals of placement plans are discussed and recorded clearly in supervision as required by national standards. | Placement planning included as a standing item on all supervision agendas and tasks recorded appropriately with copy given to supervisee. In addition placement planning included as a standing item on team meeting & regional management meeting agenda. | Daffodil Care Service completing a review of placement planning with a national working group outcome of which to be included in future organisational placement planning developments |
| | Centre management must ensure that all mandatory training takes place at the earliest opportunity | Training audit has been completed and all core trainings have been booked. Child Protection/Children's First E-Learning has been circulated to all staff to be completed by the 23rd March 2018. | Mandatory core training is scheduled on a National Annual Training Schedule. Any time delays arising will be addressed by the training components being covered in detail during team meetings and supervision to support staff in fulfilling their duties and obligations in advance of the scheduled training. |

| 3.5 | Centre management must ensure there are further improvements made in how placement planning is linked to the STEM model of care and how identified goals and actions in respect of aftercare preparation are better evidenced in these plans | Placement plans have been reviewed by centre manager to ensure STEM model of care and aftercare preparation is reflected throughout. | Placement plans will be reviewed by centre management on a bi-monthly basis to ensure adequate refection of the STEM model of care and that aftercare preparation is evidenced throughout. |
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| 3.6 | Centre management must ensure that individual crisis management plans are separate to risk management and behaviour support plans and staff are clear about the differences<br><br>Centre management must ensure that the significant event review group analyses the antecedents, staff interventions, application of ICMP and other plans and outcomes for learning purposes | Individual crisis management plans have been reviewed by management in consultation with a number of TCI trainers and the document template was assessed as fit for purpose and in line with best practice. Risk Assessment training has been implemented and is being rolled out across Daffodil Care Services teams to support the use of our risk assessment framework.<br><br>Centre manager and senior management have reviewed SERG process to include attendance of a staff member from each centre and involve them in the review the significant events and to ensure feedback to the staff team with SERG feedback included | Social care manager to ensure that only relevant information is contained in the individual crisis management plan and that it gives a complete overview of the young person's potential behaviour and appropriate intervention strategies. Staff attendance at the monthly SERG meeting and feedback to be a standing item on team meeting agenda.<br><br>Senior Management (Director of Service, Assistant Director of Services or Director of Quality Assurance) will attend regional management meetings including the Significant Event Review Group, on a rotating basis to ensure compliance and |

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| | | as a standing item for team meeting following regional management meeting. | quality, ICMP's have been added to the documents reviewed by this group. |
| | The centre manager must review the absence management plan in the centre to ensure it is in keeping with Children Missing from Care: A Joint Protocol between An Garda Síochána and the Health Services Executive Children and Family Services, 2012. | Daffodil Care Service are currently reviewing the IAMP with IT provider with a view to removing risk assessment and retaining IAMP as a standalone document | Once IAMP format is available centre manager to ensure correct format is in use for all young people in the centre. |
| | Centre management must ensure that there is a definite feedback loop from the SERG to the staff team, that all staff members understand the process and that the learning and recommendations are evident across the records. | A staff member will attend monthly SERG meeting and be involved in the review process and ensure feedback is given to the team as a standing item at the next scheduled team meeting following SERG – 22.02.18 | SERG feedback to become a standing item on team meeting agenda. Staff will also be included in the selection of the Significant Event for review at SERG. Senior Management review and Oversight to occur |