An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 030

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Don Bosco Care**
Registered Capacity:	**Five young people**
Type of Inspection:	**CAPA Review**
Date of inspection:	**20th & 21st August 2024**
Registration Status:	**Registered from 13th December 2023 to 13th December 2026**
Inspection Team:	**Lorraine Egan** **Cora Kelly**
Date Report Issued:	**14th October 2024**

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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 and Regulation 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 a corrective and preventative actions (CAPA) review 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 CAPA review, the centre was in its eighth registration and was in year one of the cycle. The centre was registered without attached conditions from the 13th December 2023 until 13th December 2026.

The centre was registered as a multi occupancy unit to provide medium to long term care for up to five young people from 12 to 17 years on admission. The centre's model of care was operated day to day 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 CAPA review.

1.2 Methodology

The inspectors examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated the 4th and 5th of October 2023. The inspectors requested that the centre management submit all relevant documentation to demonstrate their progress in implementing the CAPA. A range of records were forwarded including audit reports, management and team meeting minutes, significant event review meetings, young people's feedback, training trackers and the centre's policy and procedures document. These were reviewed remotely by the inspectors and a meeting was conducted with the centre manager via MS Teams to gather further information.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of those concerned with this centre and thank all involved 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 2nd September 2024. The findings of the CAPA review was used to inform the registration decision.

The findings of this CAPA review has determined the centre to have substantially implemented the required actions and therefore 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 2023 to 13th December 2026 pursuant to Part VIII, and 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 9: Access Arrangements

Theme 1: Child-centred Care and Support

Standard 1.5 Each child develops and maintains positive attachments and links with family, the community and other significant people in their lives.

Issue Requiring Action:

- Centre management must develop a policy and procedure for escalation of relevant matters for action to senior management and social work departments.
- Centre management must amend their policy document and information booklets to include detail on the Tusla 'Tell Us' policy.

Corrective & Preventative Actions:

- Centre management (CM) raised the need to have a policy for escalation of relevant matters at senior management meeting 23/10/2023. Agreed that this policy will be drafted and brought to the next policy group meeting held.
- Young persons' booklet and family booklet have been updated to include information on Tusla 'Tell Us' policy on 23/10/2023.
- CM will notify senior management via the procedures outlined in the escalation policy in a timely and recorded manner.
- CM will ensure that all relevant and appropriate advocacy and support services available to young people and their families, are supplied to young people and their families upon admission to the centre.

Review Findings:

Overall, there was evidence on the centre records submitted to inspectors that there was a commitment by the centre manager to respond to the findings of the previous inspection and implement the corrective actions and preventative strategies outlined by them in the CAPA. Improvements were observed in the auditing systems undertaken along with a response to the specific complaint issue that had been identified by inspectors in the previous inspection.

The centre had developed a draft escalation procedure as part of a wider policy on 'Resolving Multi-agency Professional Disagreements'. The content of the policy primarily outlined the steps to take to resolve problems and differences between the staff team and other agencies working with the young people living in the centre. While an escalation process was outlined within the document, inspectors found that further development was required to include issues that are not getting appropriate or prompt responses from young people's relevant social work departments as identified previously. At interview, the centre manager described an escalation procedure to respond to these specific issues, however, it was unclear to inspectors if this was now part of routine practice and therefore followed in every case. Inspectors saw evidence on centre documentation, that the specific matter highlighted in the findings of the previous inspection regarding one young person, had been escalated appropriately by the centre manager post inspection. Inspectors were told by the centre manager that the draft escalation policy had yet to be signed off by senior management and would subsequently be implemented with the staff team.

The young person's guidebook and the family leaflet had been updated to include a link to information on the Tusla complaints policy 'Tell Us'. Inspectors suggest expanding both so that information is outlined to explain how the service operates as a support to young people and their families. For the most recent admission of a young person to the centre, Tusla's complaints and feedback policy was discussed, and staff described how the young person could access the service if needed. 'Tell Us' was also discussed at team meetings with staff; however, this did not take place until July of this year. The complaints policy had not been reviewed to reflect this relevant information.

Further Actions Required

- No further actions as CAPA implementation is in progress and ACIMS satisfied with timeframes.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 9**
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 1.5**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

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

Theme 5: Leadership, Governance and Management

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

Issue Requiring Action:

- Senior centre management must implement a formal system of auditing the safety and quality of care against the national standards as a matter of priority.
- Centre management must implement a unified and robust system of monitoring, analysing, and acting upon information relating to complaints, concerns and incidents with evidence of learning shared to promote practice improvements.
- The registered provider must ensure that priority is given to conducting an annual review of compliance with the centre's objectives.

Corrective & Preventative Actions:

- The centre manager (CM) will implement a monthly governance audit that will be carried out by the CM and the social care team leaders (SCTLs) with the CM holding responsibility for oversight each month. This will begin in November 2023. In-depth file reviews will continue to be carried out by a SCTL from another team.
- The CM will ensure that the complaints process is fully integrated into practise development processes such as the significant event review group (SERG) meetings, monthly audits and training needs analysis updates. The organisation's complaints officer will liaise with the CM and the centre's complaints officer on quarterly basis.

- External consultants will be employed to review all current auditing and compliance matters and make recommendations. This will be completed by March 2024. The CM and director of service (DOS) will ensure adequate resources are given to this task.
- The CM will report to the DOS on a monthly basis with a completed governance audit. External auditing of monthly governance reports will also be carried out by the CM of a sister service.
- Monthly auditing, alongside in-depth file audits and quarterly visits from the complaints officer will ensure that the day to day in-house practise is promoting practise improvements.
- The CM and DOS will implement the recommendations from the external consultants regarding how the procedure and formatting of the annual review, as well as scheduling workable repeat dates with adequate resources and delegation amongst the centre's leadership structure.

Review Findings:

Inspectors found that a system of monitoring had been implemented in the centre by the centre manager and the director of service. Auditing by the centre manager with the support of social care team leaders had commenced in January 2024 and had occurred monthly to date. The audit template in use was partially aligned to the National Standards for Children's Residential Centres and as a result only a portion of information relating to the criteria within the themes could be captured. The data and findings that was identified, provided a general overview of the care provision for young people on a monthly basis such as individual risks, a number of their current needs, the amount of complaints made and the significant events that took place. However, sections of the monthly audits were not completed including the self-assessment and the key performance indicators.

Additionally, two external audits were undertaken by a social care leader from a sister centre in November 2023 and April 2024. These audits were specific to files belonging to two young people's living in the centre. One was a general review which highlighted gaps in care planning for the young person that required attention. The second was structured to include five specific standards and contained comprehensive information along with a clear action plan for implementation. However, this document would benefit from timeframes and persons assigned named in the action plan. Follow-up meetings were held after the audits took place where aspects of the findings were discussed with the staff team. Guidance and direction was provided to staff to action any outstanding deficits and address ongoing issues for young people including their escalation to appropriate social work departments.

There was strong evidence of learning being shared amongst the staff team to promote practice improvements in young people's overall care.

Inspectors found that there was scope for further development within these monitoring processes specifically for the inclusion of additional criteria from the standards within the monthly audits. Also, they recommend that centre and senior management consider the findings gathered on a monthly basis so these can be utilised for tracking deficits in service provision in a consistent way. Analysis of the trends emerging from more regular auditing would be beneficial for improving outcomes further for young people. In addition, a commitment was given to employ external consultants to review all current auditing and compliance matters by March 2024. This had not been achieved and the centre manager told inspectors there was a resource issue in this regard.

An external review was completed relating to complaints, incidents and concerns in July 2024. This took account of the outstanding complaint one young person had made that had been identified in the previous inspection. Four formal complaints had been assessed in this audit and some clear suggestions and recommendations for action were outlined within the document. A follow-up meeting with the staff team was held to discuss the recommendations and implement a plan to address the gaps identified. This included amendments to the complaints process so that keyworkers took responsibility for ensuring their key young people were satisfied with the way dissatisfactions were managed. In addition, the complaints officer was tasked with monitoring the procedures on a monthly basis. Ongoing review of complaints was also scheduled twice yearly by a centre manager from a sister centre.

There was strong evidence on team meeting minutes that learning from the number of audits undertaken so far was shared with the staff team and utilised as an opportunity to improve practice with young people. Two significant event review meetings had taken place also and these showed in depth reflection by the team from the incidents discussed. The team were swift to respond and change practice as a consequence of this analysis. An annual review of compliance had not been conducted. The centre manager told inspectors this was planned for November 2024 and a template had been developed in advance of the first meeting.

Further Actions required

1. No further actions as CAPA implementation is in progress and ACIMS satisfied with timeframes.

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 5.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Theme 6: Responsive Workforce

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support

Issue Requiring Action:

- A comprehensive training needs analysis must be undertaken and matched with a programme of continuous training and professional development, the implementation of which must be overseen by the centre manager.

Corrective & Preventative Actions:

- The training needs analysis document supplied to the inspectors will be further developed by CM through consultation with the centre's team leader's and supervisors, identifying core training for the whole team, along with individualized training goals identified for team members. This will be in place for January 2024.
- The training needs analysis will continue to be a standing item at the centre's team leader meetings and will be reviewed in conjunction with the training officer on a bi-annual basis. All team members will be supported to register with CORU when this opens.

Review Findings:

The previous inspection identified that a comprehensive training needs analysis (TNA) should be undertaken to determine the training needs of the staff team. However, while a TNA was submitted to inspectors, it had been recorded on a word

document only and it generally reflected a selection of core and mandatory training completed by the staff team. Child protection and safeguarding was not identified in the document nor was supplementary training to support the direct work with young people. This requires further development so that the organisation responds appropriately to the implementation of a programme of continuous training and professional development for the staff team.

There remained a responsibility on individual staff to have their mandatory training up to date and for example, staff had to self-schedule the behaviour management training online when it required renewal. The individual requests by staff for specific training needs are identified briefly in the TNA. The centre manager said that these suggestions and requests were gathered at the team meetings and through supervision. From a review of sample team meeting minutes and management meetings, there was evidence of this happening regularly. However, the gaps highlighted in the findings of the previous report remain regarding the consistent recording, follow up and tracking of training overall for the staff team. A comprehensive training plan with timeframes for the centre should be developed. A training log was in place that recorded core training completed by staff such as behaviour management, first aid and fire safety. Further improvement is needed to develop the log for tracking and monitoring purposes. Oversight should also be provided by the centre and senior management.

Further Actions required

1. No further actions as CAPA implementation is in progress and ACIMS satisfied with timeframes.

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 6.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**