An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 049

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Four Young People**
Type of Inspection:	**CAPA Review**
Date of inspection:	**9th & 10th July 2024**
Registration Status:	**Registered from 5th of March 2022 to the 5th of March 2025**
Inspection Team:	**Lisa Tobin** **Lorraine Egan**
Date Report Issued:	**19th August 2024**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 preventive 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 March 2012. At the time of this CAPA review the centre was in its fourth registration and was in year three of the cycle. The centre was registered without attached conditions from 5th March 2022 to the 5th of March 2025.

The centre was registered as a multi occupancy short to medium term centre catering for up to four young people of mixed gender between the ages of sixteen and nineteen years of age on admission. Its specific purpose was to prepare young people for leaving care, independent living, and adulthood. The model of care was based on the systemic therapeutic engagement model (STEM) which was described as providing a framework for positive interventions with young people. It supported the development of relationships which focused on achieving strength-based outcomes through daily life interactions and targeted programmes. It draws on a number of complementary philosophies and approaches including Circle of Courage, Response Abilities Pathways, Therapeutic Crisis Intervention and Daily Life Events. There were four young people living in the centre at the time of the inspection, two of whom were over 18.

1.2 Methodology

The inspector examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated 14th & 15th November 2023. Inspectors remotely reviewed documentation sent by the centre manager and conducted an online interview with the centre manager to discuss the actions taken since the last inspection relevant to the CAPA.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 25th of July 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 fully/ 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: 049 without attached conditions from the 5th of March 2022 to 5th of March 2025 pursuant to Part VIII, and 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies Regulation 17: Records
Theme 1: Child-centred Care and Support

Standard 1.3 Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.

Issue Requiring Action:

- Centre management must ensure that young people's contributions to decisions made about their care are consistently reflected across their records.
- Centre management must ensure that issues raised by young people at group meetings are brought to staff team meetings for discussion and decisions made recorded on the minutes. Follow up with young people should be consistently taking place.

Corrective & Preventive Actions:

- Each young person will be offered the opportunity to have input into the development of monthly placement plan, which will be recorded and attached to each document. Where a young person chooses not to engage, the efforts made by the staff team, will be recorded. Implemented – 8th December 2023.
- The completion of monthly consultation with young people will be overseen by the case manager and reported in the centre's monthly governance report. The compliance officer will review these reports and provide commentary of the adherence to this expectation on a monthly basis.
- A review of the young person's meetings was completed by the centre Management Team on 04.12.23. Where information on feedback from the team meeting was not recorded, this was added. The team meeting template was updated to prompt review of young people's meeting at each team meeting. Implemented 8th December 2023.
- As part of the standing items of the team meeting, items raised at the young person's meetings will be discussed and minuted. The centre management team will review the young person's meeting records on a monthly basis and ensure that feedback is explicitly recorded.

Review Findings:

Inspectors found that there were improvements made in the area of ensuring the young people's contributions to their care was captured. This was evidenced in the young people's monthly placement planning consultation forms, individual works and with having the opportunity to make complaints. Inspectors saw that the staff encouraged involvement from all young people, however one of them refused engagement in anything related to a formal way of working. Staff used the opportunity of conversation while out in the car or in general day to day activities to ensure they captured any areas of development the young person identified. This young person was currently not engaged with support services and the centre management, staff and the social work department were working towards relevant supports being provided. Any specialist external supports previously offered were refused by the young person.

Senior management oversight was evident throughout the paperwork and in the centre monthly reports and by the compliance officer in the governance and service audit. These gave clear indications where young people were met with by staff to complete relevant goals and undertake works around these goals. Actions were also identified in the audit by the compliance officer which were completed by the staff.

When reviewing the team meeting minutes, inspectors found that the young people's meetings were discussed however in the sample provided there weren't any general issues raised by the young people. The group meetings were not working due to the young people's schedules and were moved to individual meetings. There were complaints raised by the young people and these were discussed during the team meetings. The complaints process was utilised when necessary and the centre manager oversaw the process. Inspectors could see the beginning of the complaints process and the outcome; however it was not clear within the complaints form what steps had been taken in order to get to the outcome. When inspectors interviewed the centre manager about the complaints processes, this was also unclear as to the practical steps taken to come to a resolution.

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 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 1.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Regulation 5: Care Practices and Operational Policies

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

Issue Requiring Action:

- Centre management must ensure that all behaviour support plans are consistently updated and on file for all young people. Improvements are required so that interventions outlined in the supporting documents are clear and easy to follow in practice.
- Senior and centre management must ensure that the warning and consequences system in place is reviewed for use with young people. Young people's dissatisfactions in relation to behaviour management approaches in use in the centre should be managed under the centre's complaints system.
- Centre management must ensure that all SENs are fully completed and reported in a timely way to all appropriate professionals. MCIC forms should be maintained on each young person's file. SENs should be aligned clearly on the centre's register with young people's individual completed forms.
- Senior management must ensure that learning from SERG meetings are clearly documented and shared with the staff team.
- Centre management must ensure that all restrictive practices in use are recorded on the young people's care record and monitored on an ongoing basis in line with centre policy.

Corrective & Preventive Actions:

- A review of all placement plans was completed by the centre management team on 05.12.23 to ensure that there was clear plans and interventions in place relevant to the behaviours of each young person. The completion of placement plans was discussed at a team meeting on 04.12.23, where guidance on the completion and updating of forms was discussed.
- The centre management team will complete a review of all placement plans on a bi-weekly basis. Where incidents occur which require a review and update of the placement plans, the completion of this will be recorded as management comments. In addition, the regional manager will complete an audit on placement planning in the centre, which will include a review of daily logs, handovers, MPR, SENs YP files etc.
- All warnings and consequences will be recorded on sanction reports, which will also record the young person's response, the completion of which will be reviewed by the centre management team. Where there is dissatisfaction expressed by the by the young people, the complaints process will be applied. Implemented 8th December 2023.
- The centre management team will review all sanction reports and report their findings in the centre's monthly governance report. In addition, the regional manager will complete an audit on complaints in the centre, which will include a review of other documents to ensure that the young people are being responded to in an appropriate and timely fashion.
- The centre management team will discuss the completion of SEN's at the centre's management meeting on 04.12.23 where deficits in reporting will be discussed. Any SEN that continues for longer than 24 hours an update is provided to all professionals via email and the CRS team is updated via the Tusla portal. New SEN checklist is implemented to ensure all documentation is in place and accounted for. Implemented from the 28.11.23. For example staff must tick off that the MCIC form is attached to the SEN, the email is attached & IWR completed. The SEN register will be reviewed by centre management on a bi-weekly basis to ensure SEN's match the register.
- The regional manager will continue to oversee all SENs sent from the centre, and where reports are incomplete or there are delays in sending SENs this will be addressed with the centre management team. In addition, the regional manager will complete an audit on placement planning in the centre, which will include a review of daily logs, handovers, MPR, SENs YP files etc. The regional manager will also sign off on the SEN register to ensure all SEN's match the register. Monthly review of SENs is discussed and documented in the regional SERG meeting minutes.

- The Centre Manager will ensure that Regional SERG review meetings are brought to team and management meetings and explicitly recorded in the centre's meeting minutes. Implemented 8th December 2023.
- The regional manager will review team meetings which occur after SERG meetings to ensure that feedback from these meetings is clearly recorded.
- The centre manager completed a review of all instances of restrictive practices on 05.12.23 to ensure that they are accompanied by a sanction or risk assessment form. The centre manager will also ensure that all instances of restrictive practices are discussed and updated on a regular basis.
- The centre management team will review all reports relating to restrictions on a monthly basis and record their findings in the centre's Monthly Governance Report.

Review Findings:

Placement plans were forwarded to inspectors for review for all the young people. Behavioural support documents such as the individual crisis support plans (ICSP) and practice approaches were also reviewed along with relevant risk assessments that had been implemented. From this review, inspectors found that there were good connections between the documents and that they were clear in what the responses from staff should be. In some circumstances, inspectors found that the care approaches were clearer for some young people compared to others. The placement plans had goals identified for each young person based on where they were at. However, it was not evident for three of these placement plans if the goals had been completed as this column had been left blank. Placement plans were discussed at the team meeting on the 4th December 2023. Inspectors saw reference to a placement plan audit being completed by the regional manager.

Inspectors reviewed the sanctions and found that those in place currently related to warnings for young people regarding house rules being broken or due to dangerous behaviour in the car. There was evidence of the sanctions being reviewed and removed where necessary. Not all sanctions captured the young person's response and improvement required with this aspect. The centre's audit and the quality assurance audit reviewed the sanctions in place to ensure appropriate steps were in place.

There was a new significant event notification (SEN) checklist in place. The centre manager felt this was supporting the improvements around managing all documents related to significant events. The centre manager stated there were ongoing issues

with individual works not being completed post SEN's but that there had been improvement in this since it had been identified during a compliance audit. This was brought up with the team at the following team meeting. There was an SEN register in place, which was overseen by the centre manager. Inspectors found that the entry numbers were incorrect, and this was rectified by the centre manager. SEN's were reviewed by the regional manager through an audit and actions were identified for the centre manager to complete.

A sample of SERG meetings were reviewed by the inspectors. In the more recent SERG's undertaken there was a new table which gave a synopsis of the incidents regarding numbers, learnings for the team and if the escalation process was required. These were discussed at team meetings to ensure staff were informed of the learning and outcomes of the SERG.

From the documentation reviewed, there was one restrictive practice in place identified for one young person. There was evidence of this being implemented, the reasons associated, and when it was reviewed. This remained in place post review due to ongoing concerns. When the team felt that the behaviour was no longer a concern the restriction was removed.

Further Actions Required:
No further actions as CAPA implementation is in progress and ACIMS satisfied with timeframes.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
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 3.2**
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 management must ensure that all corrective actions from the deficits identified in the centre's auditing and monitoring system is completed.
- Centre management must ensure that child protection and welfare referrals are clearly logged in the centre register so that they can be consistently monitored and analysed.
- The registered provider must ensure that specific designated liaison person training (DLP) is completed by the appointed DLPs.
- Centre management must ensure that a record is maintained of all young people's complaints/dissatisfactions, including details of the investigation and resolution. Young people have a right to be informed of the outcome and their response recorded on their file. Learning from trends identified should be communicated to staff.

Corrective & Preventive Actions:

- A full review and evaluation of all audits is scheduled to be completed in December 2023, which will include the tracking of identified deficits. Regional manager will ensure corrective actions are addressed.
- The revised auditing system will be implemented from January 2024, which will incorporate all levels of oversight. The tracking of actions identified, and their resolution will be completed by the quality assurance manager.
- The centre management team completed a review of the SEN register on 30.11.23 and ensured that all CPWRFs were recorded and easily identifiable.
- The centre management team will review the SEN register when completing centre's monthly governance report. In addition, the regional manager will complete an audit on child protection in the centre in 2024.
- The centre manager will complete a full review of training, including DLP training in December 2023. DLP Training is booked in for the 23.01.24 for

centre management. Where deficits are found, courses will be booked or escalated as being required.

- The centre management team complete bi-monthly training reviews to identify any training gaps and where courses are unavailable, they will be escalated and requested through the regional manager.
- The centre manager will discuss the complaints policy at the team meeting on 04.12.23 focusing on the application of the policy and the expectations around recording the response to the young people including their level of satisfaction to this response. The complaints folder is to be reviewed and monitored bi-weekly by the centre management team to ensure that a record is maintained of all young people's complaints. Any learning from complaints by the young people should a pattern be identified must be updated into the ICSPP for the young person. Complaint feedback/ outcome with the young person must be documented via an IWR or through the complaints procedures and communicated clearly with the young person.
- The regional manager will complete an audit on complaints in 2024, which will include a review of other documents to ensure that the young people are being responded to, are provided with feedback and that their level of satisfaction is clearly recorded.

Review Findings:

An auditing schedule was implemented across the organisation for 2024 which took into account who was responsible for completing these and when they would be completed. There were audits undertaken by centre management, the regional manager and by the compliance officer. Part of this process included a review of the CAPA actions and the implementation of them.

Inspectors reviewed the SEN register which captured when child protection welfare report forms (CPWRFs) were submitted. It was noted that the reference number was missing for some CPWRFs, and this register did not give space to allow for updates or outcomes to be reflected. Inspectors recommend a separate register for CPWRFs to ensure all relevant information can be provided including the ongoing status of the report. In reviewing the centre monthly reports, inspectors found these had better information about the status of the CPWRF's compared to the SEN register. A child protection audit was completed recently by the regional manager in line with the organisations schedule in June and July, with actions identified for the manager to complete. The feedback for this had yet to be given to the team.

Training for the designated liaison person (DLP) and the deputy had been completed by the centre manager and the deputy manager. Training certificates were forwarded to the inspectors.

A complaints audit was completed in February 2024 by the regional manager. There were no actions identified. There was a complaint's register in place, inspectors noted the majority were described as non-notifiable even though some were notified complaints. Improvement noted over time, but all areas should be filled in on the register. It was not clear if complaints were opened, closed or ongoing from the register and this needs to be reviewed to give more clarity. Complaints were identified on the agenda for policy review as part of the team meetings on the 1st of April and 10th of June 2024, however there was no detail on what the discussion entailed.

During interview with the centre manager while discussing complaints, it became apparent that one young person who had hearing difficulties had not participated in a fire drill since their arrival two months previous, there were no suitable fire notification systems in place for this young person and the staff had commenced received training in Irish sign language (ISL) on the 4th July 2024. This had been identified as a notifiable complaint by the centre. Given the knowledge the centre had of the needs of the young person, the above fire safety issue should have been addressed as part of the planning for their admission and not two months post admission.

There were numerous audits completed within the centre both internally and by the compliance officer. These were very detailed and gave a good understanding of what was happening in the centre with the different areas reviewed. However, it was unclear how all the audits were impacting on the practical care of the young people based on the outcomes and actions identified. The centre manager during interview was able to give some examples of how the audits impact on the staff and what was required of them as a result of the audits, but there was a gap in understanding how these processes were benefiting the young people.

Further Actions Required:

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