An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 064

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Solis DMC Children's Services**
Registered Capacity:	**Four young people**
Type of Inspection:	**CAPA Review**
Date of inspection:	**10th, 11th and 14th September 2024**
Registration Status:	**Registered from the 20th June 2023 to the 20th June 2026**
Inspection Team:	**Cora Kelly** **Eileen Woods**
Date Report Issued:	**11th November 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 actions 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 on the 20th of June 2011. At the time of this CAPA review the centre was in its fifth registration and was in year one of the cycle. The centre was registered without attached conditions from the 20th of June 2023 to the 20th of June 2026.

The centre was registered as a multi-occupancy service for up to four young people. It aimed to provide medium to long term care with a focus on relationship building and positive behaviour support. The model of care was based around the work of Psychologist Erik K Laursen's *Seven Habits for Reclaiming Relationships*. The registered age range was thirteen to seventeen upon admission. There were four young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the progress made by the centre with the implementation of the CAPA from the previous inspection on the 4th and 5th of April 2023. The inspectors requested that centre management submit all relevant documentation to demonstrate their progress in implementing the CAPA. A range of records were forwarded including medication records, placement plans, young people's feedback forms, complaint records, governance reports, team meeting minutes, a training tracker 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 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 27th of September 2024. The findings of the CAPA review were used to inform the registration decision.

The findings of this CAPA review have determined the centre to have not fully implemented the required actions and that further work is required. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 064 without attached conditions from the 20th of June 2023 to the 20th of June 2026 pursuant to Part VIII, and 1991 Child Care Act. A further full inspection of this centre will be carried out in early 2025.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6

Issue Requiring Action:

- The centre manager must ensure that the young people are provided with feedback on any issues they raise on the bi-monthly feedback forms. This must be documented on the form and signed by the appropriate person undertaking the task.
- The centre manager must ensure that all aspects of the complaints form are captured online to include the outcome of the complaint and the young person's feedback.

Corrective Actions:

- A new Bi-monthly feedback form has been developed which includes a section for Management to provide feedback. A second form which is just for management will provide detail of the conversation between management and young person and will be triggered for completion once the manager has read the bi-monthly form to ensure this work is completed.
- A new complaints form has been developed which not only includes the details of complaint but when it was dealt with and a full section to provide feedback in relation to the outcome. A section has also been added to allow the young person making the complaint pass comment on whether they were happy with the outcome and the manner and time in which it had been dealt with. This will allow for any further issues to be resolved in a timely manner.
- Once completed this will automatically go to the PIC for approval. The new system will notify the management to complete follow up forms and will remain active on the system until this is completed.
- All complaint forms that have been completed and submitted within the clear care system are directly sent to the PIC for approval. This in effect means that no complaint form can be closed off until the PIC has read through and is happy with the actions taken and the young person is happy with the actions completed by staff/management team in dealing with the complaint. A new

governance document has been introduced which captures whether complaints have been closed off or remain opened.

Review Findings:

In response to the last ACIMS inspection in April 2023 it was the inspectors findings that the centres bi-monthly feedback form had been updated to capture feedback by centre management to issues raised by young people. To enhance centre managements oversight of this mechanism the form was moved to the centres online system in July 2024 with a reminder on the online calendar to ensure that the young people are provided with the forms every second month. A paper version of the form was also available to the young people. The form was consistently utilised by the centre for all four young people residing in the centre. The inspectors found from their review of a sample of team meeting minutes and monthly governance reports that young people's feedback was not discussed or tracked through these processes. The inspectors recommend that this occurs to ensure that the voices of the young people are heard by staff and internal and external management and that it is included in service improvement plans for the centre.

As required, the centres online complaints form was updated to include the outcome of the complaint and the young person's feedback. To date this year a total of two complaints were recorded in the centres complaints register. Of these one was found to have been managed in line with policy with the complaint form completed in full. However, for the second complaint made in March 2024 the inspectors were unclear during the CAPA review process as to what type of a complaint was made i.e. a formal or informal complaint. On their review of all complaint and supplementary records provided it was their finding that an informal complaint was made by the centre on behalf of the young person who had expressed dissatisfaction regarding their placement on four occasions since February 2024. This was not in line with the centres policy on complaints. It was recorded in the governance report for June 2024 that the complaint was closed and that it would be discussed at the young person's child in care review. A date for this had yet to be scheduled. In managing the complaint, the inspectors did not evidence the actions the centre took to address anything specific in the placement that the young person was unhappy with. Overall, the inspectors found that the centre failed to comply with their own policy in managing the complaint. On their review of the centre complaints policy the inspectors found that there was a lack of information on what constituted a complaint and the procedures for managing informal and formal complaints were not clear. Further, the complaints form itself or the centres complaint register did not capture the two types of complaints. In contrast to policy complaints was not found to have

been a key agenda item at team meetings for regular discussion or learning. Whilst the governance form had consistently captured complaints the deficits around centre practices found during this CAPA review were not captured.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 16** **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 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Regulation 10: Health Care
Regulation 12: Provision of Food and Cooking Facilities

Theme 4: Health, Wellbeing and Development

Standard 4.2

Issue Requiring Action:

- The centre manager and the relevant social work departments must ensure that any necessary interventions and recommended supports required for the young people are secured in a timely manner.
- The centre manager must ensure that the placement plans are updated in line with recommendations from the care plan regarding the young people's health and well-being. They must be updated more frequently and be clear with identified goals and outcomes.
- The centre manager must ensure that the young people's medical files have all the relevant medical forms on file, including consent and immunisation forms.

- The centre manager must ensure all staff complete safe administration of mediation training.
- The centre manager must ensure there is oversight of the administration of medication including information on any medication given and the reason why must be documented on the young people's files.

Corrective Actions:

- The centre endeavors to seek any supports that are needed for the young people within its care whether this be through public or private services. This will be done in conjunction with the relevant social work teams if funding is required. The management team will continue to seek this support on a monthly basis if it is not provided in a timely manner.
- A review of the placement plans has been secluded for the 31.05.2023 which will also include social care leaders, social care workers and young people. This will allow for all parties to have a say in the development of the placement plan. The proposed actions being put forth are that the placement plan will be reviewed every three months and will place the focus on three sections identified with the care plan, to allow for a greater focus on the goals and outcomes.
- All relevant medical forms have been requested by centre manager and are now on file.
- Safe administration training has now been sourced for the number of staff who have yet to receive this training within Louth Hall. Currently we are waiting a confirmed date for this training to take place however it should happen during the month of July.
- Management has a new system in place which is overseen by the new deputy who has started in their post within the centre. The new system will be overseen by a social care leader on a weekly basis with the deputy manager taking full oversight of medication to ensure it is robust and that all information is correct.
- Each young person's key work team will keep in regular contact with the social worker, any recommendations that were made through reports will be followed up on. At the end of each month the key workers will notify the management team if there has been progress or if there is anything outstanding so that this can then be followed up. Management will follow up in line with the centre escalation process if needed.
- A rolling Placement plan is in development with it proposed launch being that of the 1st of June. This will be updated and reviewed every three months by

key work teams and management to ensure greater level of focus on identified areas and recommendations from care plans.

- The Deputy manager along with social care leader now have direct oversight of the medication files to ensure that everything contained with said folders is up to date. This will be completed weekly with an email being sent to PIC to keep them aware of any issues.
- A new training tracking system has been developed and implemented within the centre. Once the dates of training completed has been added it will notify management three months before the expiry date of any training, or if a staff member is missing any mandatory training.
- The social care leader who has been assigned to medication oversight will now check the medication files on a weekly basis. A weekly email is now being sent to the PIC which outlines the status of the medication folders. This will allow a greater level of oversight within the team and from a management and governance level.

Review Findings:

Inspectors found evidence that the acting centre manager and the relevant social work departments were working collaboratively in securing identified interventions and supports for young people. Whilst some supports were not accessed timely there was evidence of centre management being proactive in obtaining these. Clear processes were in place for the staff team to assist the centre manager with this task.

The format of the centres placement plans was revised and updated in July 2024 following the ACIMS inspection of this centre in 2023 and feedback received from the ACIMS inspection of a sister centre in January 2024. The placement plan record was more focused and allows for both short- and long-term goals to be set across a number of areas for example family, education, social skills, health and well-being and activities/ hobbies/ interests. A three-month review process was introduced to replace the six-monthly review. Due to the process being new in the centre the inspectors were not able to comment on the outcomes of the goals. They did evidence a placement plan for one young person that included the health and well-being actions that were decided at their recent child in care review.

Centre management provided evidence of the specific young people's medical records being held on their care files. The deputy manager and a social care leader had a weekly responsibility in ensuring that the young people's medical files contained all required information, that the file is kept up to date and keeping the centre manager updated too by email. There was no specific record in place for this task.

The inspectors found from their review of the centres training needs analysis and certificates provided that a total of seven staff, all of whom commenced working in the centre since April 2023, completed training in the safe administration of medication (SAMS) in May 2024. The acting centre manager and four remaining staff completed their training in the months of January, April, March and September 2024. The acting centre manager and a social care leader, who had worked in the centre since 2022 had not been provided with the training in July 2023 as stipulated in the centres 2023 CAPA form. As part of this CAPA review process the inspectors were informed that staff are required to complete supplementary online medication management training via HSeLanD. To date, two staff were found to have completed this training in June 2023. This training was not recorded on the centres training analysis record.

It was not evident to the inspectors that the acting centre manager had oversight of the administration of medication in the centre. In interview the acting centre manager confirmed that information on medications prescribed was held on the young people's files, but the reason why was not documented. Medication errors occurred on two occasions this year within a two month time frame where one young person was given medication prescribed for a different child and another young person was given a larger dose of their prescribed medication. Whilst the incidents were appropriately responded to by staff at the time of their occurrences the inspectors did not evidence from their review of relevant paperwork of any follow up by centre or external management to prevent them from re-occurring. One medication error occurred in April 2024 with the staff member involved having been trained in the HSeLanD medication management only. They were not provided with SAMS training until May 2024. It was clear that procedures outlined in the centres medication policy were not followed.

The inspectors were informed that the four young people's medication was stored in three medicine cabinets. It was evident from a number of photographs of the cabinets that were provided to the inspectors that the medication prescribed for two young people were stored on single shelves in one of the cabinets with single cabinets in place for the other two young people. The inspectors found that for one of the young people who was prescribed a controlled medication, it was not stored in a locked box in their medicine cabinet. This did not comply with centre policy where it is stated that *'controlled drugs should be locked within the secure storage unit in a separate compartment'*. It is further stated that *'access to the keys, including those for the controlled drugs storage, should be limited to trained staff only'*.

As a stock control measure staff had responsibility for completing monthly medication audits. The format of the audit did not include if staff had been provided with or had up-to-date medication related training or if medication errors had occurred. Of the audits completed from January to June this year no actions were yielded despite the deficits identified during the CAPA review.

Compliance with Regulations	
Regulation met	**Regulation 10** **Regulation 12**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1

Issue Requiring Action:

- The centre must only consider the use of back-to-back shifts in emergency circumstances to continue the consistency of care.

Corrective Actions:

- The centre now operates a 3- 4-month rota which allows for greater oversight regarding shift patterns. All staff have been notified that all swap changes must be passed through management first and that no shifts can be swapped that places a staff member on back-to-back shifts.

- Centre Manager has now taken over full oversight of the staff rota including the development of quarterly rotas to reduce any back-to-back shifts unless in an emergency situation.

Review Findings:

The inspectors reviewed a sample of staff rotas over 2023 and 2024 and found that centres use of back-to-back shifts had decreased significantly. They were informed by the acting centre manager that it was used on eleven occasions and in emergency circumstances only. There was evidence of risk assessments completed at these times and a three month rota was in place to allow the acting centre manager time to plan for gaps in the rota and ensure that the centre was staffed at all times.

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

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