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: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Don Bosco Care**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Dates of inspection:	**4th & 5th of October 2023**
Registration Status:	**Registered from 13th December 2020 to 13th December 2023**
Inspection Team:	**Catherine Hanly** **Lisa Tobin**
Date Report Issued:	**27th November 2023**

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 an inspection 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 inspection the centre was in its seventh registration and was in year three of the cycle. The centre was registered without conditions from the 13th December 2020 until 13th December 2023.

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 inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Child-centred Care and Support	1.5 only
4: Health, Wellbeing and Development	4.3 only
5: Leadership, Governance and Management	5.4 only
6: Responsive Workforce	6.4 only

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, some of the allocated aftercare and social workers. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

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.

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 16th of October 2023. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 26th of October 2023. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA 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 2020 to 13th December 2023 pursuant to Part VIII, 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.

Inspectors found evidence of the recognition by the staff team of the importance of family contact for young people and significant efforts to continuously promote positive contact for each young person with various family members. Family contact was facilitated at the centre for young people who wished to have their family members visit. The one young person inspectors spoke with informed inspectors that visits by family members was well respected by everyone in the centre. There were sufficient rooms in the home to facilitate visits in a private space, and the home had recently been extensively refurbished creating a warm, homely, and inviting space. Young people's views and wishes were at the forefront of decision-making in relation to contact arrangements and there was awareness of the inclusion of parents' views also. One young person had celebrated their birthday at the centre the week prior to this inspection and there were cards still on display. Their family members had visited them in the home for their birthday and the day had been marked in accordance with their wishes. It was evident to inspectors that the value placed on family contacts, and the efforts that the staff team went to in ensuring this was positive and appropriate was a real and genuine strength of the team.

The young person that inspectors spoke with informed them that their friends were welcome to visit the centre but that they chose not to have this happen for now. There was a recognition amongst the staff team of the importance of building friendships for young people and some key work records reflected discussions with them about appropriate social interactions and expectations. There were efforts to encourage and maintain interests for young people outside of the centre, such as horse riding. Generating interest in, and getting young people to continue with interests outside of the centre, has proven to be an area that has challenged the staff team with the current group of young people, and it would be good to see some innovative and creative thinking and practices around this especially with a view to further admissions.

Young people had access to televisions, mobile phones, and other electronic devices. Staff monitored and supported the young people with these to lessen the problematic consequences of excessive use.

One young person, and their parent, had been raising the matter of sibling access for a protracted period with centre staff and the allocated social worker. Inspectors seen evidence of the key workers advocating strongly on behalf of the young person for the social worker to convene a meeting of the various persons involved in this matter but had been unsuccessful thus far. The matter had not been escalated by the centre manager with the social work department and inspectors recommend that a policy and procedure on internal escalation of matters that require attention be devised and implemented. This policy and procedure could be appropriately used in this situation as well as others where key workers are not getting adequate or prompt responses from the respective social work teams.

Inspectors noted that the information booklets for young people and their parents did not contain information on the Tusla complaints policy 'Tell Us'. The parent in the situation referenced above was not made aware of their right to make a complaint through this mechanism although had recently formalised their views on the matter of their children's sibling access by putting it in writing to the social work team and informing care staff of this. Relevant information on this policy should be included in the centre policy document, as well as the information booklets for young people and their families. All staff, young people and their parents should be appropriately informed about this.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 9**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 1.5**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- 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.

Theme 4: Health, Wellbeing and Development

Standard 4.3 Each child is provided with educational and training opportunities to maximise their individual strengths and abilities.

Inspectors found evidence of practices that supported young people to continue with their educational placements. This included regular, in some cases daily, communication between centre staff and the various professionals in the young peoples' respective educational setting. Staff worked with young people and their schools to encourage young people to engage regularly in education and made amendments to the schedule to further enhance participation. For one young person, there was active efforts in conjunction with their school to alter their curriculum to increase their participation. It was evident that each young persons' views about their own educational attainment, ability and interests was considered by the staff team, whilst also encouraging continued attendance.

There were good records of previous educational achievements and school progress reports on individual care files at the centre. There was evidence that alternative educational and training options had been explored to be creative in engaging young people that struggles with mainstream education. Inspectors reviewed an educational assessment report on file for one young person which included specific actions for their educational placement that were being implemented. A second young person did not have an educational assessment on their file although inspectors were informed that one had been completed. Inspectors requested that a copy of this be secured for the main file and the manager and allocated social worker should ensure that any recommendations therein are being actioned appropriately. At the time of this inspection, a meeting had been scheduled for the staff team and social worker to meet with the educational team in part to determine what additional supports were required for the school placement. At the time of this inspection, the third young person had undergone a multidisciplinary assessment process, and the social worker and centre were awaiting the detail of this in the associated report.

One young person informed inspectors that they really did not like school, and this was reflected in their inconsistent attendance. Having said this, they referenced discussions that they had had with staff to develop their independence in getting to and from school on their own.

Compliance with standards	
Practices met the required standard	**Standard 4.3**
Practices met the required standard in some respects only	**Not all areas under this standard were assessed**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- None identified.

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.

Inspectors found evidence of an embedded approach that put young people at the heart of the work in this centre. Key workers were strong advocates for the young people and strived to support them in meeting their needs and encouraged them to utilise the various supports and interventions available to them. The three young people residing in the centre at the time of the inspection had been there for varying periods of not less than one year and up to three years which demonstrated stability in the context of their respective placements. Weekly reports and team meeting minutes, as well as regular multi-disciplinary strategy meetings for one young person were reflective of in-depth discussions related to reviewing the quality of care provided and the safety afforded to young people in this placement.

Inspectors were provided with file audits that had been completed on each young person's care file maintained by the centre at varying stages over the previous eighteen months or so. These audits had been completed by a social care leader from another centre within the organisation and submitted to the centre manager for action. The audits were stored in each individual file with updates on actions documented throughout as and when it occurred but without dates or persons responsible for implementing actions named. Whilst these audits were broad, they were generally descriptive in content which made the implementation of actions more difficult to track.

Separately, internal management meetings showed discussion at that level of assigning responsibility to each of the social care leaders to take on the task of reviewing the themes within the National Standards for Children's Residential Centres document. The development of this had not been realised to any great extent at the time of this inspection. The interim director of services informed inspectors during interview that the Board of Directors had given a commitment to the realisation of a formal auditing system against the National Standards themes. The development of a template for this process was reported as having commenced. A formal system of auditing the safety and quality of care against the national standards must be implemented as a matter of priority.

Inspectors found that there were individual records of formal complaints maintained, alongside summary entries into a centre register. The two individual records reviewed relevant to the previous twelve months were documented on loose-leaf pages that were left inside the front cover of the hardback register. These records must be immediately moved to the individual care file for safe and secure storage. Informal complaints were recorded in individual files as 'grievances'. The title of these records should correspond with the wording in the centres' policy document which makes a distinction between formal and informal complaints. Inspectors noted that one young person had twenty-six recorded informal complaints in their individual 'grievance register' so far for 2023. There was no evidence that these had been reviewed for any patterns or themes emerging and to identify any action required to respond to these matters.

Inspectors were informed that the centre manager of a sister centre within the agency had recently conducted an audit of complaints but that a written report of the findings of this audit had not been provided to centre management at the time of this inspection. The centre manager was unable to recall with inspectors any verbal feedback provided from this audit and there was no feedback documented in team meeting minutes reviewed by inspectors.

Inspectors were informed that a significant event review group (SERG) was convened on a quarterly basis. This mechanism reviewed selected significant events across multiple services within the agency catering for under eighteen and young adult service users. Those events selected for review were deemed as being priority for discussion by the relevant service managers. The centre manager informed inspectors that no event occurring in this centre had been presented for discussion in this SERG mechanism in 2023. There were several episodes of one young person being detained for periods of several months because of criminality; as well as other significant events including a young person being arrested, significant drug misuse, and reported child protection concerns for young people at the centre. None of these

had been presented for discussion at the SERG forum and it was unclear to inspectors how or why incidents were prioritised for discussion at that forum. Strategy meetings had been convened regularly for one young person due to escalating risk and the associated impact on the continued safety of their placement. Separately, a risk assessment conducted in July had determined the need for the implementation of safety plans for two young people to monitor the safety of their interactions within the placement. These safety plans were undated but titled 'live' documents. They were identical across the two files, as opposed to being separate given the behaviours displayed by one were impacting on the other and thus the safety plan for each should reflect the individual implications for each. There was no recorded review of these safety plans since their commencement which was presumed to be July, to coincide with the risk assessments, three months prior to this inspection. Inspectors did not find evidence through the records they reviewed of complaints, concerns, and incidents outside of these cited examples being monitored, analysed, and acted upon. The SERG mechanism must be reviewed to ensure that significant events occurring in this centre are being regularly reviewed for analysis and action.

An annual review of compliance with the centre's objectives to promote improvements in work practices and to achieve better outcomes for children had not been conducted. The interim director of services informed inspectors that this matter had been discussed at senior management level within the agency and the Board of Directors had given approval for the development and implementation of this annual report. Senior management must ensure that this review of compliance is conducted as a priority with timely action taken to address improvements as necessary.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 5.4**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required

- 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.

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.

The centre manager provided inspectors with a record of staff training completed within the last three years. One of the social care leaders had been delegated the responsibility of having oversight of training records, with individual staff members required to forward certificates of training to them upon completion. The record provided to inspectors showed mandatory training had been completed in areas including fire training, first aid, medication management, and Children First. There was evidence that there were significant supports available to the manager and staff team to further develop themselves professionally and complete formal training which, in turn should feed into service development and improvement. These supports were both financial and time released from duties to study. The centre manager had commenced further studies, having recently completed a degree programme and the staff members interviewed spoke about the ongoing encouragement from the centre manager to develop themselves further professionally.

There had been a training needs analysis report completed by internal management, but inspectors found that this examination of staff training needs as well as the staff training record provided required much more development by centre management. It did not account for difficulties experienced by this agency in securing mandatory training in therapeutic crisis intervention, a matter that had been noted by the agency during an inspection of another service within the agency. The document also lacked in specificity regarding how the training needs identified would be achieved. One staff member spoke in interview of their desire to secure formal training in an area

that would benefit their work and interventions with one of the young people. This training had been mentioned in consecutive internal management meetings spanning the previous five months but there had not been a plan realised to achieve this. During the previous inspection of another centre within the agency, the interim director of services had discussed the plans at senior management level to further develop the agency's approach to and delivery of training and professional development for staff across the organisation. They had indicated that these plans would be realised through the financial commitment of the agency. Inspectors did not find that there had been any formalisation of this plan yet within this centre. A comprehensive training needs analysis needs to be undertaken to determine the actual training needs of the staff team, in consideration of the centre's stated purpose and giving due consideration to the presenting needs of the young people. This then requires the registered provider to respond appropriately to identified needs in the implementation of a programme of continuous training and professional development that should be overseen by the centre manager.

Inspectors were informed that there was a formal induction for staff, and this was supported by a policy. Records of this were provided to inspectors for review. One staff member described their experience of this process in detail and remarked that it had been of benefit to them in commencing their employment at this centre.

Compliance with standards	
Practices met the required standard	**Not all areas under this standard were assessed**
Practices met the required standard in some respects only	**Standard 6.4**
Practices did not meet the required standard	**Not all areas under this standard were assessed**

Actions required:

- 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.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	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.	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 info 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 Drumcondra.
4	N/A		
5	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.	CM will implement a monthly governance audit that will be carried out by the Cm and SCTLs, with the CM holding responsibility for oversight each month. This will begin in November 2023. In-depth file reviews will continue to be	CM will report to Director of service (DOS) on a monthly basis with a completed governance audit. External auditing of monthly governance reports will also be carried out by CM of sister service.

		carried out by a SCTL from another team. External consultants will be employed to review all current auditing and compliance matters and make recommendations this will be completed by March 2024.	
	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.	CM will ensure that complaints process is fully integrated into practise development processes such as SERG meetings, monthly audits and training needs analysis updates. Organisation complaints officer will liaise with CM and Drumcondra complaints officer on quarterly basis. External consultants will be sourced to review all current auditing and compliance matters and make recommendations this will be completed by March 2024. CM and DOS will ensure adequate resources are given to this task.	Monthly auditing, alongside in-depth file audits and quarterly visit from complaints officer will ensure that the day to day in house practise is promoting practise improvements. 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.
6	A comprehensive training needs analysis must be undertaken and matched with a programme of continuous training and professional	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	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

	development, the implementation of which must be overseen by the centre manager.	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.	bi-annual basis. All team members will be supported to register with CORU when this opens.