An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 150

Year: 2019

Alternative Care Inspection and Monitoring Service
Tusla - Child and Family Agency
Units 4/5, Nexus Building, 2nd Floor
Blanchardstown Corporate Park
Ballycoolin
Dublin 15 - D15 CF9K
01 8976857

Registration and Inspection Report

Inspection Year:	**2019**
Name of Organisation:	**Ashdale Care**
Registered Capacity:	**Four young people**
Dates of Inspection:	**10th, 11th, 23rd September 2019**
Registration Status:	**Registered from 29th March 2019 to 29th March 2022**
Inspection Team:	**Linda Mc Guinness** **Cora Kelly**
Date Report Issued:	**29th November 2019**

Contents

1. Foreword

The National Registration and Inspection Office of the Child and Family Agency is a component of the Quality Assurance Directorate. The inspectorate was originally established in 1998 under the former Health Boards was created under legislation purveyed by the 1991 Child Care Act, to fulfil two statutory regulatory functions:

1. To establish and maintain a register of children's residential centres in its functional area (see Part VIII, Article 61 (1)). A children's centre being defined by Part VIII, Article 59.
2. To inspect premises in which centres are being carried on or are proposed to be carried on and otherwise for the enforcement and execution of the regulations by the appropriate officers as per the relevant framework formulated by the minister for Health and Children to ensure proper standards and conduct of centres (see part VIII, Article 63, (1)-(3)); the Child Care (Placement of Children in Residential Care) Regulations 1995 and The Child Care (Standards in Children's Residential Centres) 1996.

The service is committed to carry out its duties in an even handed, fair and rigorous manner. The inspection of centres is carried out to safeguard the wellbeing and interests of children and young people living in them.

The Department of Health and Children's "National Standards for Children's Residential Centres, 2001" provides the framework against which inspections are carried out and provides the criteria against which centres structures and care practices are examined. These standards provide the criteria for the interpretation of the Child Care (Placement of Children in Residential Care) Regulations 1995, and the Child Care (Standards in Children's Residential Centres) Regulations 1996.

Under each standard a number of "Required Actions" may be detailed. These actions relate directly to the standard criteria and or regulation and must be addressed. The centre provider is required to provide both the corrective and preventive actions (CAPA) to ensure that any identified shortfalls are comprehensively addressed.

The suitability and approval of the CAPA based action plan will be used to inform the registration decision.

Registrations are granted by on-going demonstrated evidenced adherence to the regulatory and standards framework and are assessed throughout the permitted cycle of registration. Each cycle of registration commences with the assessment and

verification of an application for registration and where it is an application for the initial use of a new centre or premises, or service the application assessment will include an onsite fit for purpose inspection of the centre. Adherence to standards is assessed through periodic onsite and follow up inspections as well as the determination of assessment and screening of significant event notifications, unsolicited information and assessments of centre governance and experiences of children and young people who live in residential care.

All registration decisions are made, reviewed and governed by the Child and Family Agency's Registration Panel for Non-Statutory Children's Residential Centres.

1.1 Centre Description

This report sets out the findings of an inspection carried out to monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in March 2019. At the time of this inspection the centre was in its' first registration and in year one of the cycle. The centre was registered without attached conditions from the 29th March 2019 to 29th March 2022.

The centre's purpose and function was to accommodate four young people of both genders from age ten to fourteen on admission. Their model of care was described as providing specialist residential care for young people with complex emotional and behavioural issues who could not be adequately cared for in a mainstream residential setting. The centre aimed to provide a responsive, specialist service as an alternative to more secure forms of care to meet the social, emotional, behavioural, therapeutic, health and educational needs of the young people. This was through a person-centred therapeutic service that had clinical direction and was based on emotional containment and positive reinforcement. The environment was designed to support young people in developing internal controls and promoting resilience and responsibility.

The inspectors examined standard 2 'management and staffing', standard 5 'planning for children and young people' and aspects of standard 6 'care of young people' of the National Standards for Children's Residential Centres, 2001. This inspection was unannounced and took place on the 10th, 11th and 23rd of September 2019. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

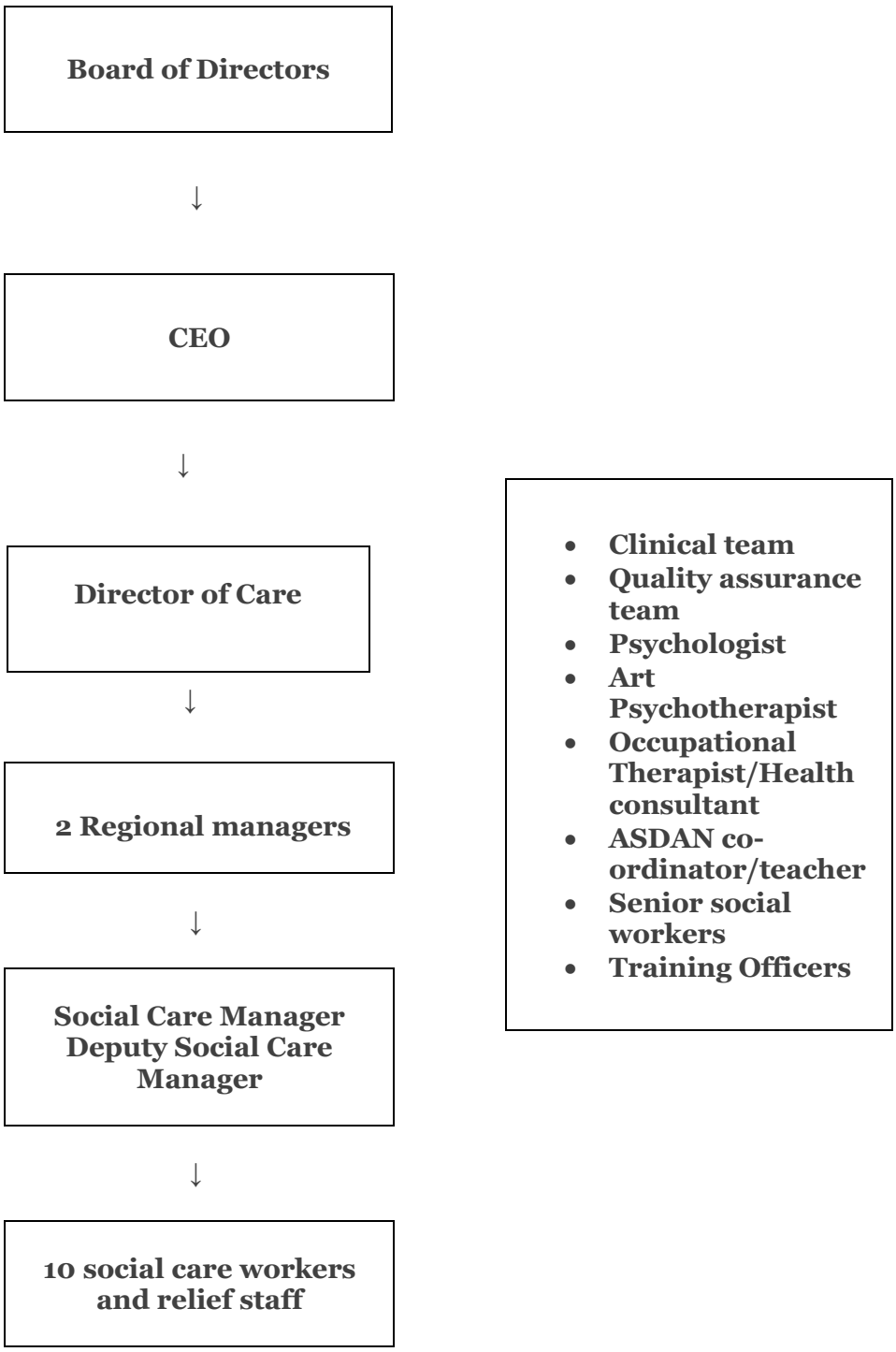
This report is based on a range of inspection techniques including:

- An examination of the inspection questionnaire and related documentation completed by the manager
- An examination of the questionnaires completed by:
    a) Eight of the care staff
    b) The social care manager
    c) The incoming social care manager
    d) The deputy manager
    e) The social worker for one young person
- An examination of the centre's files and recording process including:
    - Both young people's care files
    - Staff supervision records
    - Personnel files
    - Handover book
    - Management meeting records
    - Operations visits
    - Centre audits
    - Team meeting minutes
- Interviews with relevant persons that were deemed by the inspection team to have a bona fide interest in the operation of the centre including but not exclusively:
    a) The centre manager and proposed new manager
    b) The deputy manager
    c) Two of social care staff
    d) The social workers for both young people
    e) The guardians ad litem for both young people

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 person, staff and management for their assistance throughout the inspection process.

1.3 Organisational Structure



2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 18th October 2019. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 6th November 2019 and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing to operate in adherence to the regulatory frameworks and Standards in line with its registration. As such, it is the decision of the Child and Family Agency to register this centre, ID Number: 150 without attached conditions from the 29th March 2019 to 29th March 2022. pursuant to Part VIII, 1991 Child Care Act.

3. Analysis of Findings

3.2 Management and Staffing

Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

3.2.1 Practices that met the required standard in full

Register

Inspectors conducted a review of the centre register and found this to contain details on the name, gender and date of birth of the young person as well as admission and discharge dates. The centre register met regulatory requirements. There was a system in place where duplicated records of admissions and discharges were kept centrally by TUSLA, the Child and Family Agency.

Notification of Significant Events

The centre had a system for the prompt notification of significant events. Social workers who were interviewed confirmed that they were satisfied with the prompt notification and effective communication relating to significant events. The centre had a significant event register that provided details of each incident in the centre and there was evidence of oversight of this register by senior line managers.

Administrative files

Inspectors reviewed a number of the administrative files in the centre and found these were well maintained and facilitated effective communication and planning for young people. Records were held in line with the Freedom of Information Act, 2014 and were stored securely. The social care manager and the quality assurance team had systems in place to monitor the quality of the records being kept in the centre and to rectify any deficits noted. Inspectors also noted that there were adequate financial arrangements in place.

3.2.2 Practices that met the required standard in some respect only

Management

The centre had a full time manager who had been in post since this centre was registered in March 2019. This person held a qualification in social care and had

extensive experience as a residential care manager prior to taking up this role. This person had initially been recruited to take up a manager's post in another centre which was being established and was due to move in the weeks following this inspection. A replacement person had been identified and was working alongside the manager until this transition took place. Senior management must make efforts to ensure that management changes are kept to a minimum particularly during the establishment of a new centre and a new team.

At the time of inspection both managers were present during normal office hours and shared overall responsibility for the day-to-day running of the service. Inspectors observed evidence of their governance of the centre on a daily basis across centre records and audits. They reviewed young people's daily logs, care files and centre registers. One of the managers usually chaired staff team meetings and attended handover meetings and was always present at child in care reviews and professionals' meetings. The managers were supported in their role by a deputy social care manager who also worked normal office hours. Inspectors found that with the current availability of an extra manager there was often a manager or deputy manager working alongside the residential care staff. This was described as part of the modelling and supportive process to a very inexperienced team. This would cease when the social care manager moved to their new position. Senior management must ensure that all necessary measures are in place to ensure all required supports to this inexperienced team. This centre did not have a senior social care practitioner which is normal within the organisation's structure, but it was envisaged that one would be allocated to the centre when the organisation's senior practitioner programme was completed in the coming weeks. There was an out-of-hours on-call service to support staff in the event of incidents occurring at evenings or weekends when no manager was on site.

The centre manager reported to the regional manager who had a regular presence in the centre. A new quality assurance system saw a regular schedule of announced and unannounced audits take place against the National Standards for Children's Residential Centres, 2001. Implementation of any recommendations was overseen by the regional manager although progress of these was difficult to track at the time of inspection as formal action plans were not available. The centre manager also created a weekly operations report that was forwarded to the regional manager and senior management. These reports included details on the placements and outcomes for young people, staffing, child protection and health and safety and other operational issues.

Records reflected six regional manager and other senior management visits to the centre since the first young person was admitted in May 2019. Regular communication took place both formally and informally between the centre managers and senior management. There was evidence that the director of care was taking an organisational approach to responding to the findings of recent inspections across the organisation with recommendations being implemented across all centres if relevant.

There was a strong focus on supporting the staff team who were all new to residential care and had minimal experience. This was evident by the manager's presence on the floor, through supervision records and formal and informal reflective practice. Inspectors reviewed the records of manager's meetings which took place regularly and found that these were well attended. There were a wide number of operational and service delivery issues addressed at this forum and records also reflected discussions related to risk management, care practice and the planning of care for young people. There was an emphasis on the implementation of a new model of care to which the organisation had signed up for with an international organisation. Organisational training and reflections days had taken place in support of the transition to the new model. Management and staff interviewed during inspection gave positive feedback about the proposed change.

In the four months since the admission of the first young person internal file audits had been conducted by centre management and three formal audits by the organisation's internal quality assurance team and director of care had taken place. These were based on standards 2, 4 and 5 of the relevant standards and the manager was responsible for the implementation of recommendations and reporting these to line management. There was no formal action plan to facilitate tracking of actions and this is recommended. Some of the recommendations such as bringing keyworking to supervision for review or completion of induction checklists were not yet fully implemented. Senior management must ensure that quality assurance mechanisms have appropriate follow-up in respect of implementations of any actions required in a timely manner.

Training and development

Inspectors reviewed the training log and certificates in the centre and found that staff had up-to-date training in children first e-learning and had completed the organisations child protection training during induction. There were some gaps in relation to fire safety for more recently appointed staff and these must be completed as a matter of priority. Some staff members were also awaiting first aid training. Staff

had received training in a recognised model of behaviour management and de-escalation which included the safe use of physical intervention. Some staff had also received training in supervision, suicide and self-harm prevention, child sexual exploitation, domestic violence and alcohol awareness. The organisation also had a training awareness programme (TAP) which was overseen by the clinical team and included training in attachment and loss, trauma, mindfulness, and post crisis response amongst others. These were now taking place three times per month and there was an expectation that each staff member would attend a set minimum amount of sessions annually. The organisation had a training officer who co-ordinated a training needs analysis and the roll out of supplementary training. There was a computerised system in place to ensure that refresher training occurred in a timely manner for courses requiring updates.

Staffing

The organisation had a comprehensive policy relating to the recruitment and selection of staff. This centre had a staff complement of a social care manager, a deputy manager, and 10.5 social care workers. There was also a manager in transition working alongside the social care manager at the time of this inspection. There had been significant changes to the staff team from the original team presented with the application for registration with seven new people appointed to this team. Five people had left and two others had not actually started as planned. It was noted also that two of this team were only working in the centre until a proposed move with the social care manager to another centre opening within the organisation. Organisational management must ensure that the centre has a stable team to implement the model of care. Recruitment and retention measures and policies should ensure that changes are kept to a minimum and that there is consistency of care provision to young people.

The roster was comprised of two overnight shifts each day plus a support shift until 9pm. Inspectors found that there was enough staff to meet the centre's purpose and function. All staff members were appropriately qualified however a majority were inexperienced in the field of residential care. A number of the team were still completing a probation period and inspectors found that the centre did not have a balance of experience among the team and there was not a staff member at child care leader level on each shift. This was being managed by ensuring that a manager or deputy manager worked alongside staff wherever possible. Centre and senior organisational managers were aware of this inexperience and there was evidence through supervision, operations reports and staff team meeting minutes that they were attempting to support staff. Arrangements had also been made to have a senior

support worker (who was also the behaviour management trainer) complete 20 hours per week in the centre for a period. It was proposed that a senior practitioner would be joining the team in the weeks after the inspection.

Through interview and the questionnaires completed, inspectors noted that the staff team were familiar with care practices and operational policies. While they were very committed to each young person and had built some strong relationships, inspectors found that much of the work was fire fighting, focused on managing extremely challenging behaviour and many assaults. Despite the best efforts of the team and many strategy meetings a decision had been reached in the days before inspection that the situation was not sustainable and that young people would experience further harm if it were to continue. An alternative placement was being explored for one of the young people.

The organisations' HR person was responsible for staff personnel files and these were well organised and managed professionally. Inspectors conducted a review of a sample of these files and found that they contained CVs, up-to-date Garda/Police vetting and three references (one from the most recent employer) which had been verbally verified as required. It was noted however, that one reference was supplied by a deputy manager in a previous employment and no efforts had been made to verify this reference with the person in charge. References must always be verbally verified with the previous manager. There were also copies of qualifications which had been verified and details of all mandatory and other supplementary training on file.

Supervision and support

Inspectors noted there was a comprehensive organisational induction programme and evidence of probationary reviews at three months and six months for staff members. There was evidence that staff practice which fell below the required standard was addressed in a supportive and challenging manner through the probation and HR processes. The centre had a policy that stated supervision would be conducted every two weeks during the first six weeks of employment for new staff and monthly thereafter. Inspectors found that supervision always took place within the required time frames. The function of supervision of the team was split across the manager and deputy manager and a plan was in place to transfer supervision to the new manager. All supervisors were trained in the provision of supervision through a recognised model. While there were supervision contracts on file for each staff file reviewed some were not signed by both parties.

The centre manager was supervised by the deputy regional manager and also by the organisation's head of training, governance and policy as part of a dual process which saw specific responsibilities and agendas set for each. The training officers' supervision had a greater emphasis on professional development while the other sessions were focused on organisational, operational and care practice issues. Review of the records showed that while the template indicated a focus on the care and progress of young people neither of the supervision processes had an adequate focus on case management and this should be addressed. Inspectors noted that although the proposed new manager had been working in the centre for some time they had not yet received formal supervision in that role from the regional manager. The director of care must review the dual supervision records and process in place for managers to ensure that it is fit for purpose and that aspects of the process are not neglected.

As would be expected with an inexperienced team, there was an appropriate focus on skills development through supervision. While there was some evidence that placement planning, key working and behaviour support plans were discussed there was a lack of detail and actions relating to these processes and this requires improvement. The supervision of the deputy social care manager had a clear focus on supporting staff to build skills and confidence and their supervision of staff members was reviewed in this forum.

Staff team meetings in the centre were held fortnightly. Individual development plan (IDP) meetings were held every second team meeting to support the planning of care for young people and clinical guidance was provided at these meetings. There was clear evidence of extra support for staff when physical restraint was required. The implementation of the behaviour management system was reflected upon and guidance given to staff from the senior support worker.

There was a standing agenda for the staff team meeting that included items such as child protection, complaints, significant event review, consequences and the whistle blowing policy. Young people's meetings were also an agenda item. Inspectors found that team meetings were generally well attended and there was evidence that members of the organisation's clinical team, senior managers and training officers were present on occasion to discuss issues and provide guidance to staff. Inspectors found that at times more discussion and focus was required on supporting the management of challenging behaviours and the planning of care for young people. These issues were only discussed under the heading of 'any other business' at non IDP meetings and at times there were only a few lines detailing the discussion for

each young person with no clear actions and follow up. The director of care had attended two staff meetings. The regional regional manager had attended handover meetings but had not yet attended a team meeting at the time of this inspection. Inspectors recommended they attend from time to time in order that they could identify areas of good practice or improvement required as outlined above.

3.2.3 Practices that did not meet the required standard

None identified.

3.2.4 Regulation Based Requirements

The centre met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) Regulations 1996***
-Part III, Article 5, Care Practices and Operational Policies
-Part III, Article 6, Paragraph 2, Change of Person in Charge
-Part III, Article 7, Staffing (Numbers, Experience and Qualifications)

Required Actions

- The director of care must ensure that there is a stable team to provide consistency and implement the model of care.
- The director of care must ensure there is a formal action plan and system in place to track progress of recommendations made by quality assurance auditing processes.
- Vetting processes must include verbal reference with the previous manager where a candidate was employed.
- The regional manager must ensure that team meetings contain sufficient detail relating to the discussions and implementation of placement plans, behaviour support plans and risk management.
- The centre manager and regional manager must ensure that review of placement planning, behaviour support plans and keyworking is adequately evidenced through the supervision process.
- The regional manager must ensure that the new centre manager receives formal and scheduled supervision in line with organisational policy.
- The director of care must review the dual supervision records and process in place for managers to ensure that it is fit for purpose and that the link between supervision and placement planning is not neglected.
- The regional manager must ensure fire safety training takes as a matter of priority upon employment.

3.5 Planning for Children and Young People

Standard

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

3.5.1 Practices that met the required standard in full

Contact with families

There were two young people living in the centre at the time of inspection. Inspectors found from a review of care records that regular family access was being facilitated where it was in the best interests of a young person. Strategy meetings and care planning processes were facilitating work towards increased access where difficulties existed. There was evidence that the staff team encouraged and practically supported contact with parents, family and significant others even when the young people were placed a significant distance from their referring area and home place. All family contacts were recorded appropriately on care files in the centre.

Supervision and visiting of young people and Social Work Role

Standard

Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to their care.

Social workers and the Tusla national private placement team had provided background information relating to each young person prior to placement. Where possible the views of young people and their parents were sought. Each social worker had visited their young person in the centre and where it was safe to do so met with them privately. The social workers interviewed following the onsite inspection spoke highly about the commitment of the team and the efforts of the management and team to meet the needs of young people and keep them safe. Social workers stated that while they were confident the placement was suitable and would be able to meet

their needs it was unlikely that these two particular young people could remain together. A series of strategy meetings were planned to address this issue as a matter of urgency. Social workers had read their young people's records held in the centre as required. The centre kept a record of every social work visit and contact with the team

Emotional and specialist support

The organisation had a dedicated clinical team which included psychologists, art psychotherapist, occupational therapist, social work and teaching staff. Members of the clinical team attended the young people's individual planning meetings once per month and the placement plan was updated every eight weeks. There was evidence that they gave guidance to the management and team in relation to understanding and responding to young people's challenging behaviours. External support was also sought in consultation with the social work department for specific behaviours a young person was presenting with. A sensory needs assessment had begun and it was intended that this when completed would facilitate targeted planning for this young person. Another young person attended art therapy regularly and was waiting for dates for a psychological and educational assessment to commence.

There was evidence that the staff, while inexperienced were aware of the emotional and psychological needs of young people. However, the risks relating to the dynamics between the young people were extremely difficult to manage and this was recognised by all relevant professionals. It should be noted that notwithstanding the very challenging behaviours and frequent assaults that social workers, other professionals and the clinical team felt that each young person was making slow progress in their own right.

Children's case and care records

Inspectors found evidence that the care files for young people had been audited by the quality assurance team and that any deficits were noted and being rectified. Records were written to an appropriate standard and there was evidence that the social care manager, regional manager, social workers and guardians ad litem had reviewed the files.

The care records were kept in a manner that facilitated ease of access and the tracking of information. Key work sessions and preparations for review meetings reflected that young people's views were sought in a child friendly way.

3.5.2 Practices that met the required standard in some respect only

Suitable placements and admissions

This centre was registered in March 2019 and there had been two admissions since that time. The centre accepted referrals from the Tusla National Private Placement Team and also from social work departments in Northern Ireland. The centre created both individual and collective preadmission risk assessments and there was evidence that staff had discussions at team meetings to plan for meeting the needs of young people. However, there was no evidence that the preadmission risk assessments were reviewed and agreed by social work departments prior to the admission. Inspectors recommend that this occurs in future. A number of issues of high risk and their possible impact of these on each young person were identified at the outset of the second placement. Inspectors note that the inexperience of this team was not considered a factor when making the decision to progress the second admission. Given the complex nature of both these young people inspectors found that information was available which may have predicted the difficulties which subsequently arose. Centre and senior management must ensure that full consideration is given to all issues at the pre admission risk assessment phase to ensure suitability of placements and an appropriate mix of young people.

Each young person was provided with information on the placement presented in a child friendly format. There was on going work with each of the young people to ensure that they understood the reason for their placement.

Statutory care planning and review

Both young people in this centre were under 12 years of age. Inspectors reviewed the care files and found that one had a care plan dated 01/07/19. This was not up to date in line with the *National Policy in relation to the Placement of children aged 12 years and under in the Care or Custody of the Health Service Executive*. The social worker for this young person informed inspectors that the care plan was being finalised and would be provided to the centre as soon as possible. The next review meeting was scheduled for 12/09/19. The second young person had a care plan dated 29/07/19 and a review meeting was scheduled for 09/09/19 which was slightly outside national policy.

Supervising social workers must ensure that statutory child in care review meetings take place in line with national policy and that an updated and signed care plan is provided following each statutory review. Inspectors found that while the service had created their own minutes following statutory review meetings there were no Tusla

records/minutes of child in care statutory reviews. Social workers must ensure that a formal record of the meeting is made available for the child's file.

3.5.3 Practices that did not meet the required standard

None identified.

3.5.4 Regulation Based Requirements

The Child and Family Agency has not met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995***
-Part IV, Article 23, Paragraphs 1 and 2, Care Plans
-Part V, Article 25 and 26, Care Plan Reviews

The Child and Family Agency has met the regulatory requirements in accordance with the ***Child Care (Placement of Children in Residential Care) Regulations 1995***
-Part IV, Article 22, Case Files.
-Part IV, Article 23, paragraphs 3 and 4, Consultation Re: Care Plan
-Part IV, Article 24, Visitation by Authorised Persons

The centre has met the regulatory requirements in accordance with the ***Child Care (Standards in Children's Residential Centres) 1996***
-Part III, Article 17, Records
-Part III, Article 9, Access Arrangements
-Part III, Article 10, Health Care (Specialist service provision).

Required Actions

- The director of care and regional manager must ensure that full consideration is given to all issues at the pre admission risk assessment phase to ensure suitability of placements and an appropriate mix of young people.
- The supervising social workers must ensure that it they meet all regulatory obligations in respect of care plans and care plan reviews. A care plan must be provided after statutory child in care review meetings and a record of the minutes of the meeting kept on file.
- Supervising social work departments must ensure that child in care review meetings for young people aged 12 and under take place in accordance with national policy.

3.6 Care of Young People

Standard

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

3.6.1 Practices that met the required standard in full

Managing behaviour

The centre had a policy in respect of challenging behaviour and a written policy on sanctions which was consistent with promoting the developmental needs of young people. Every effort was made to ensure that young people had clear expectations in relation to behaviour and that they understood why sanctions were in place. If used, sanctions were recorded in a separate book for monitoring purposes. There was evidence that despite their relative inexperience that the team were committed to responding to young people in an age appropriate way and that they were supported by management on the floor when behaviours became extreme. It was evident that they sought to understand the causes of challenging behaviour and address them in a child focused way. There were individual daily plans, risk assessments and risk management plans in place. The centre had a written policy on bullying and the team made every effort to promote a positive and safe environment. Despite these policies, procedures and interventions it became apparent that they would not be sufficient to manage the risks on an on-going basis and the decision was made in consultation with both social work departments to source a more appropriate placement for one of the young people.

3.6.2 Practices that met the required standard in some respect only

Restraint

The centre used a method of physical restraint which was part of an overarching model of behaviour management. This was researched and based on reputable practice. All the team were trained in this model during their induction to the centre and refresher training was provided in a timely manner. There was a written policy in respect of restraint which was evident in practice. There was evidence to show that

staff tried other methods to deescalate young people and that restraint was only used as a last measure to protect young people or staff from immediate risk of injury.

There was evidence that physical interventions which were used were proportionate to the circumstances and the age of the young person. One young person had been restrained 33 times since admission and this was subject to review in the monthly care plan review meetings. Social workers who met with inspectors were satisfied that if physical intervention was used it was necessary and proportionate.

The use of physical restraint was highlighted separately on the significant event register and each intervention was appropriately notified to all relevant persons. There was a significant event review group (SERG) in place which reviewed every significant event notification and these were recorded on a database for tracking purposes. While this level of oversight was useful inspectors found that there could have been more forensic analysis of antecedents, interventions and outcomes of significant events which met a certain threshold. Staff members interviewed during the inspection were not clear on the purpose or function of the SERG and were not able to describe any learning which was fed back from that forum. There was evidence during a period of significant instability that the centre manager and team had been requesting that a significant event review group meeting take place but this was not responded to appropriately by senior management. Inspectors recommend an organisational review of how significant events are reviewed to maximise learning, staff development, training needs or risk escalation where required.

While there was evidence that the team made efforts to engage young people in a life space interview (LSI) following significant events it was clear that they did not really have the capacity to engage in talk therapy for learning purposes. It would be useful if the organisation were to explore LSI's for younger children or those with learning disabilities.

3.6.3 Practices that did not meet the required standard

None identified

3.6.4 Regulation Based Requirements

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

Required Action

- The director of care and regional manager must review the system for analysis of significant events and how learning is communicated to the staff team following the significant event review group.
- The director of care and regional manager should explore additional tools and resources to facilitate post crisis reflection with young people who have additional needs.

4. Action Plan

Standard	Issue Requiring Action	Response with Time Scales	Corrective and Preventive Strategies To Ensure Issues Do Not Arise Again
3.2	The director of care must ensure that there is a stable team to provide consistency and implement the model of care.	Following on from the inspection senior management alongside HR met with the management teams do discuss consistency of staff teams	The director of care and HR will continue to meet as part of regular reviews in relation to ensuring that staff teams remain stable. In as far as possible we will try to ensure that there is not regular movement except for that of promotions as part of professional development.
	The director of care must ensure there is a formal action plan and system in place to track progress of recommendations made by quality assurance auditing processes.	With immediate effect	The governance committee now meet on a monthly basis, and this committee reviews all recommendations from completed quality assurance auditing. This committee ensures that all recommendations are formally tracked via the regional managers and any difficulties in relation to same is reported into the governance committee.
	Vetting processes must include verbal reference with the previous manager	With immediate effect	The company's HR department have reviewed their system for obtaining verbal

	where a candidate was employed.		references and have adopted a template to ensure that this encapsulates that they must speak directly to the previous manager (where possible) and not a representative from the place of employment.
	The regional manager must ensure that team meetings contain sufficient detail relating to the discussions and implementation of placement plans, behaviour support plans and risk management.	The Regional manager circulated an email to all centre managers in relation to ensuring that items become a permanent addition. With immediate effect placement plans, behaviour support plans and risk management will be permanent items for discussion during the team meetings	Centre manager will ensure that these items are discussed during team meetings and recorded with appropriate detail
	The centre manager and regional manager must ensure that review of placement planning, behaviour support plans and keyworking is adequately evidenced through the supervision process.	Going forward there is a strong focus on our action plans in relation to placement planning, key working and behaviour management plans. Detailed goals will be set, and this will take place with immediate effect.	Centre management will ensure that they have these points as part of the permanent agenda going forward. This will be reviewed consistently via management meetings on a monthly basis. The regional operations manager will address same during line supervision with centre manager.

	The regional manager must ensure that the new centre manager receives formal and scheduled supervision in line with organisational policy.	With immediate effect	We have amended our supervision template once again to ensure this issue does not arise again. This template will be reviewed at management meetings quarterly to ensure that it is meeting requirements
	The director of care must review the dual supervision records and process in place for managers to ensure that it is fit for purpose and that the link between supervision and placement planning is not neglected.	The Director of Care met with the two Regional Managers to review the dual supervision records and process for same and it satisfied that this process is currently being implemented and that placement planning is being reviewed through this supervision process.	Manager's supervision has now been spilt across two regions and a Regional manager for each area will be conducting manager's supervision. For any new managers in a home management role, they will be subject to the same conditions of the organisations supervision policy for all staff. Any issues in meeting this timeframe must be reported directly to the senior executive committee. Regional managers reviewed the supervision template currently in use for managers and have implemented a new format. This was reviewed again at the managers meeting on the 25/11/19 and all parties are satisfied with same.
	The regional manager must ensure fire safety training takes as a matter of	With immediate effect. Regional management will review the process for	Organisational a review of processes for fire training is being undertaken. The

	priority upon employment.	fire training alongside the training officer and management teams	organisation is now attempting to ensure that new staff receive fire training during the induction with an external fire trainer. The fire trainer will also continue to carry out fire training on a yearly basis across the homes. In the interim period, regional managers will continue to check with managers that all their staff have received an in house fire training induction before commencing their first shift.
3.5	The director of care and regional manager must ensure that full consideration is given to all issues at the pre admission risk assessment phase to ensure suitability of placements and an appropriate mix of young people. The supervising social workers must ensure that it they meet all regulatory obligations in respect of care plans and care plan reviews. A care plan must be provided after statutory child in care	Following guidance from the inspector we have amended our proposals being submitted to the NPPT to ensure that we advise at pre-admission stage of issues such as a new team to the field of residential care etc. With immediate effect	To ensure suitability of placements we now ensure that we are robust in our collaboration with social work departments in respect of group risk impact assessments and that a multi-disciplinary meeting/tele conference call is held with all social work departments involving all young people living in the centre. We will ensure to follow up on same with social work departments and escalate to senior management and within social work department if responses are not received in an appropriate time frame.

	review meetings and a record of the minutes of the meeting kept on file. Supervising social work departments must ensure that child in care review meetings for young people aged 12 and under take place in accordance with national policy.	With immediate effect	We will ensure to follow up on same with social work departments and escalate to senior management and within social work department if meetings are not taking place within the time frame set in national policy.
3.6	The director of care and regional manager must review the system for analysis of significant events and how learning is communicated to the staff team following the significant event review group. The director of care and regional manager should explore additional tools and resources to facilitate post crisis reflection with young people who have additional needs.	A review has taken place and new system have been implemented. A dedicated SEN Co-Ordinator has been appointed to the role to ensure that there are no gaps and that feedback is communicated appropriately with the teams. Our dedicated trainer plus another member of the training team are attending specific training in relation to additional needs of young people from the 11-13.11.19. The training is 'Life Space Interview for children who have developmental delay'. Following on from same this training will be implemented as	A set day has been marked in which the core SERG team will meet consistently on a weekly basis. This core team will ensure consistency of the process. The governance committee meet on a monthly basis and this will now assess if the staff teams are adequately resourced. The senior executive committee meet on a weekly basis and part of this agenda is ensuring that resources are available to the teams. Going forward the SERG team will make recommendations to the training

		part of refresher training for the staff teams.	department and senior management if it is felt that teams require additional tools/resources surplus to the mandatory training provided. Post Crisis Response training is being scheduled for all Home Managers, Deputy Managers and Senior Practitioners during the period Jan – March 2020. All remaining staff will receive training from Apr – Nov 2020