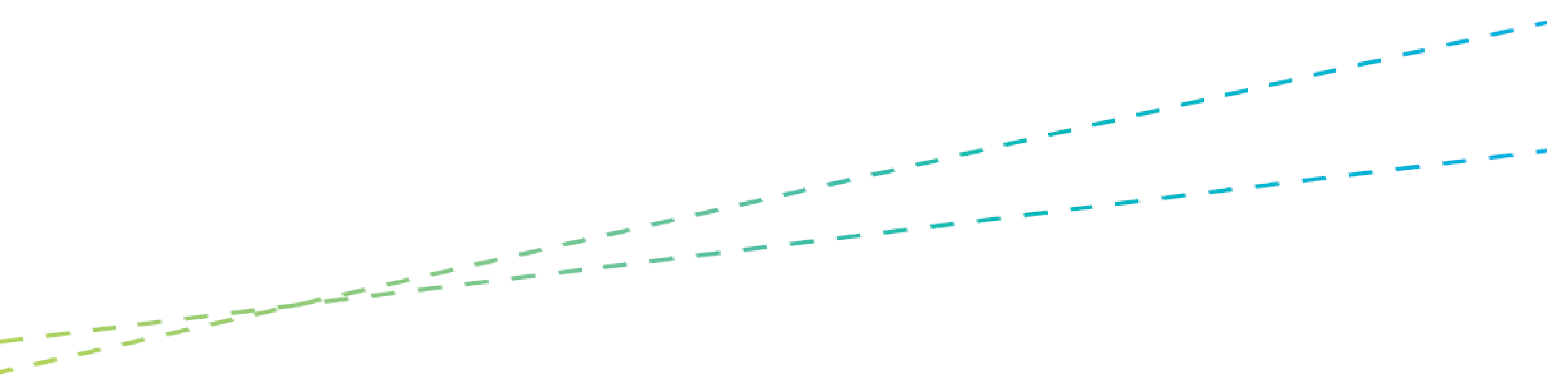
Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 020

Year: 2019



Inspection Report

Year:	**2019**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of Inspection:	**19th & 20th November 2019**
Registration Status:	**Without attached conditions from 31st March 2020 to 31st March 2023**
Inspection Team:	**Cora Kelly** **Lorraine Egan**
Date Report Issued:	**8th May 2020**

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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 Assurance 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 on the 31st March 2008. At the time of this inspection the centre was in its fourth registration and was in year three of the cycle. The centre was registered without attached conditions from 31st March 2017 to 31st March 2020.

The centre was registered to provide care for four young people of both genders from age eleven to seventeen years on admission. Their model of care was described as trauma and attachment informed and the organisation provided a training programme and clinical therapeutic team to support the staff and the young people. Four children and young people aged between nine and seventeen years of age were living at the centre at the time of this inspection. The nine-year-old was resident following a derogation process completed through the registration panel of the inspection service.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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, the allocated social workers and other relevant professionals. 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

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 3rd January 2020. 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 20th January 2020. The centres child protection policy was returned to the inspection and monitoring service on the 4th April 2020. This was reviewed as part of the CAPA and was deemed to be satisfactory.

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 re-register this centre, ID Number: 020 without attached conditions from the 31st March 2020 to 31st March 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The centres child protection and safeguarding policy and procedures were detailed across two documents. A sample of the policies and procedures included those relating to intimate care, anti-bullying, recruitment, induction, training and supervision, a code of behaviour for staff, the safe management of activities, safe practice and working alone, and complaints. With regards to the procedures for reporting child protection allegations and concerns the inspectors found that there were inconsistencies as one of the reporting procedures was found to have been in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015 with the reporting procedure in the other document outdated. Absent from both documents were the features and examples of abuse, the rights of the child and procedures relating to protected disclosures specific to staff raising concerns about the behaviour of a colleague.

Safeguarding personnel for the centre were named in the child safeguarding statement that was approved by the Tusla Child Safeguarding Statement Compliance Unit. The centre manager was the appointed designated liaison person and was supported in their role by the deputy centre manager as deputy designated liaison person. Staff were trained in the Tusla provided Introduction to Children First E-Learning module and child protection training provided by the organisation.

The inspectors found from both interviews with staff and information returned in questionnaires that staff were not aware of the correct procedures for reporting concerns and allegations of abuse. Further, those holding mandated person responsibilities were not clear of their legal role in responding to child protection concerns and allegations. The senior operations management team must ensure that a single child safeguarding document is developed and that it is in line with statutory requirements, addresses the deficits named above and that all staff then receive regular training on the updated document including relief staff members who have not received child protection training to date. A list of staff deemed as holding mandated responsibilities was not held as required in the child safeguarding statement. It was provided to the inspectors following the onsite inspection.

The centre recorded child protection concerns and reports in the register of significant events, however upon review of this register deficits were found regarding the recording of these. The centre manager must ensure that a child protection register or log is kept to record and track child protection reports and that it is managed by the designated liaison person in line with their role and responsibilities.

A number of child protection and welfare report forms (CPWRF's) had been submitted through Tusla Child and Family Agency portal since the last inspection. The majority were not closed and there was documentation evidencing centre management's efforts in following these up with the relevant social workers on an ongoing basis. There was a significant delay in one being concluded with the inspectors being informed in interview with the social worker that it was due to changes in social worker due to unforeseen circumstances. The inspectors recommend that the centre continues its efforts in concluding these CPWRF's.

There was evidence of good quality safeguarding work being completed by staff with the young people individually and as a group at the weekly young people's meetings. Staff had been provided with suitable and specific training in response to the presenting needs of the young people for example a bullying workshop that proved effective as it led to a decrease in bullying behaviours for the young people.

Safeguarding was addressed in each young people's individual development plans and they were found to be clearly linked to their care plans. The inspectors observed that the actions and goals from these plans were implemented through individual keyworking sessions that were scheduled monthly. A sample of specific and goal oriented work completed through keyworking sessions included: bullying, mobile phone safety, personal space and appropriate touch, healthy relationships, expected behaviour and online safety. From the review of the risk assessments on file the inspectors found that they were detailed and were reflective of the presenting needs of the young people. Staff in interview were clear of the daily risk assessments also in place. Risk assessments were regularly updated to address areas such as: peer relationships, social and personal boundaries, safe usage of mobile phones. In general, the preventative measures and immediate response measures were appropriate to the risks identified. There was evidence of the centre engaging in professional and strategy meetings to curtail safeguarding risks and there was good consultation with social work departments. Staff in interview were aware of the centres protected disclosure policy. Guidance for informing parents about child protection concerns was contained in the policy document.

The inspectors found that structures in place to keep management and staff updated on child safeguarding policies and procedures were broadly addressed and requires a more focused approach. This will be discussed further under standard 5.2 of theme 5.

Standard 3.2

The behaviour management policy that guided staff on the approaches and techniques in managing behaviour also focused on promoting positive behaviour on a daily basis. Staff named in interview that there was a good level of consistency amongst the staff team in responding to and managing the young people's behaviours and that their individual management plans were being adhered to. The team meetings and daily handover forum ensured that this consistency was maintained.

All staff were trained in a recognised model of behaviour management and had been provided with regular refreshers as per policy. From interviews, questionnaire and the review of young people's files staff had a good awareness of the presenting behaviours of the young people. They named individual intervention strategies in place for the young people that were found to have been in line with their behaviour management training.

The young people were aware of the expectations for their behaviour through keyworking and young people's meetings. Such information was also contained in the young person's information booklet received upon admission. The natural consequences system applied was found to have been age appropriate with the rationale for the consequence clearly outlined. The process of centre management reviewing and evaluating consequences on monthly basis was effective. Senior managements process for devising an audit tool that looked at evaluating training, behaviour management practices, rewards and sanctions was in its development stage at the time of the inspection.

Each young person had an individual crisis management plan that was found to have been regularly updated and an ongoing detailed risk assessment and management plan that addressed risks relating to safeguarding as mentioned above and also behaviours of concern. The centre manager recognised that they were not always linked to each young person's individual development plan and will address this. Therapeutic support within the organisation was available to young people in managing their behaviours. In interview social workers were positive of the behaviour management interventions and mechanisms in place.

There had been no restrictive practices in place. The small number of physical restraints that had taken place since the last inspection in January 2019 were appropriately recorded in a centre register and care files including debriefing that had taken place individually with relevant staff and young people. They were also followed up in keyworking sessions. Relevant professionals were notified as per policy. The organisation had a significant event review group that met on a weekly basis. A co-ordinator that had recently been appointed held responsibility for ensuring that feedback was appropriately communicated to the team.

Standard 3.3

All young people had keyworkers and they reported they got on well with them and that they were a good support. In interview the young people spoke positively about the staff team and that they could talk to any staff member about any issue or concern. A young person had reported their concern about a staff member's practices that affected them feeling safe in the centre. The concern was reported to the relevant professionals through the appropriate channels and was managed well by senior management. The inspectors found that staff were slow to both identify and raise their own concerns about this staff member's practices. In follow up to this the inspectors recommend that the centre manager utilises the whistle blowing section of the agenda with staff at team meetings and in supervision as well as addressing the code of behaviour in depth. A young person also informed the inspectors in interview that they felt they were treated differently that the child with the disability and that it wasn't fair on them. This was addressed by the inspectors with the centre manager and the regional manager whom were aware of it as it was a reoccurring issue. The inspectors recommend that centre management readdresses the issue with the young person.

Young people's meetings were held regularly and the sections for the voice of the young people and management feedback on actions and decisions were utilised well. Updates from these meetings were discussed at the team meetings. The people were aware of the complaints policy and it was a standing item at their weekly meetings. There was evidence of the regional manager's oversight of the complaints register and that complaints made since the last inspection were managed in line with procedures.

The centre had a system for reporting significant events (SEN's) to the relevant people including young people's parents/ carers. The significant event report forms were held on the individual care files and recorded by centre management in the centres SEN register that was overseen by the regional manager. For learning and

development purposes incidents were followed up internally through keyworking and team meetings. The recent changes to the organisations SEN review group (SERG) will ensure that specific and serious SEN's are further analysed and that learning is communicated to the centre manager and the staff team. Social workers advised that they received SEN's promptly and were satisfied with the content and quality of the reports. Parents and professionals were encouraged to comment or provide feedback on any aspect of the centres work through the complaints policy.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.3** **Standard 3.2**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**None identified**

Actions required

- The senior operations management team must ensure that a single child safeguarding document is developed and that it is in line with statutory requirements, addresses the deficits found and that all staff then receive regular training on the updated document including relief staff members who have not received child protection training to date.
- The centre manager must ensure that a child protection register or log is kept to record and track child protection reports and that it is managed by the designated liaison person in line with their role and responsibilities.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The director of care informed the inspectors that the organisations policies and procedures were being reviewed in line with the National Standards for Children's Residential Centres, 2018 (HIQA). The expected completion date of this review is March 2020 which coincides with the supplementary care model the organisation is implementing. Up-to-date policies and procedures will be required as part of their application for re-registering the centre also in March 2020. This is to include the updating of the child protection policy document so that is in line with legislation and national policy as mentioned above under theme 3. The director of care must ensure that they are developed and implemented against that time-frame. With the exception of child protection procedures staff in interview had a good understanding of the policies and procedures relating to the areas examined as part of this inspection and of the new HIQA standards. The inspectors also viewed this across centre records, young people's files and staff supervision records.

Standard 5.2

There was a governance system in place and clearly defined roles and responsibilities. From the review of centre files, questionnaires and interviews with staff it was evident that the centre manager demonstrated good leadership skills. Through the forum of professional and line management supervision and support by the regional manager there was evidence of the centre manager being supported in their role in providing leadership to the staff team. The organisations care planning approach and monthly training provided to the staff team ensured that the professional development of both management and staff was valued by the organisation in their efforts to maintaining a culture of learning, quality and safety within the centre. Senior management meetings with the director of care, regional managers and managers from the organisations other centres were held monthly. It was found from the review of these meeting minutes that the template for recording discussions did not include a permanent standing agenda with pertinent topics. The inspectors recommend that a standing agenda is set for monthly management meetings to include child protection and safeguarding practices, complaints and a review of actions from previous meetings. Similarly, for the supervision template to be updated to include these topics.

The centre manager held responsibility for completing weekly governance reports, ensuring that staff were provided with supervision, that mandatory training for staff was up-to-date, handovers were taking place daily and young people's placement plans were reviewed and developed in line with their presenting needs on an ongoing basis. The review of centre files, care files and supervision records evidenced that this was occurring and was in line with policy. Staff were found to have been clear of their role and for those with additional responsibilities for example keyworkers, they displayed a good understanding and awareness of their role. The implementation of this was evident from the review of care files.

The centres on-call policy included guidelines for staff that required support, advice or guidance outside of centre managements normal working hours Monday to Friday.

The centre had a risk management framework. It was found from the review of the framework that it was robust and allowed for good quality risk management plans for the young people that were regularly updated. Each young person had an individual crisis management plan and an absent management plan that too were regularly updated in line with centre policy.

The organisation had a service level agreement with Tusla.

Standard 5.3

The statement of purpose that was displayed in the staff office was last revised and updated in June 2019. As part of the overall policies and procedures review it will be further updated by March 2020. The centres commitment to ensuring that positive outcomes were attained for young people was named in the current statement. It was named that the centre provided mainstream residential care on a medium to long term basis for young people of both genders up to the age of 18 years. The specialist health and disability medical needs required by one child who had a disability were being met by professional services external to the organisation. Whilst it was acknowledged that they were thriving in the centre the regional manager was in agreement that a specialist placement to meet their needs would be more appropriate. In interview the social worker confirmed that they were actively exploring a placement.

The model of care was described as trauma and attachment informed and the organisation provided an ongoing training programme and had a clinical therapeutic

team to support the staff and the young people. The staff team's implementation of the model was evident in their everyday care practices in meeting the needs of the young people. At the time of the inspection senior management were in the process of developing it further with supplementary training to support the framework model being provided to by the clinical team to centre management and staff that is scheduled to take place from March 2020.

Standard 5.4

The organisations senior operations management team held responsibility for providing management support to the centre and ensuring the implementation of its quality assurance systems. In this regard, the regional manager, to whom the centre manager reported to and the quality assurance officer held specific support, governance and oversight responsibilities. There was some oversight by both across centre records and registers. Part of the regional manager's role included conducting operations visits. Through the forums of supervision, their review of weekly governance reports and being part of the organisations SERG and multidisciplinary governance committee the regional manager evidenced in interview a good understanding of the care being provided to the young people.

The inspectors were advised that the organisation was in the process of developing a governance audit framework based on the National Standards for Children's Residential Centres, 2018 (HIQA). The quality assurance officer had conducted monitoring visits during 2019 against the now outdated standards and had compiled reports and action plans following same. Timeframes of when actions contained in the plan were to be completed were not included and the inspectors did not evidence follow up of action plans at further monitoring visits. Senior management must ensure that the audit tool based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed in a timely manner and that actions plans includes time frames and are followed up.

As mentioned under theme three the organisation had recently implemented a new function to the existing SEN review group whereby learning from the external review of incidents will be communicated to the centre manager and staff team to promote improvements in practices. The inclusion of child protection and safeguarding practices and complaints across all review mechanisms in place for the organisation and centre as mentioned throughout this report will ensure that learning improvements will take place on a continual basis.

At the time of this first inspection against the HIQA standards the centre had not completed an annual review of compliance with the centre's objectives. The inspectors recommend that the director of care develops a tool to annually review compliance with the centres objectives and that timely action is taken to promote improvements in work practices to achieve better outcomes for children.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1** **Regulation 5**

Compliance with standards	
Practices met the required standard	**Standard 5.2**
Practices met the required standard in some respects only	**Standard 5.1** **Standard 5.3** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The director of care must ensure that the organisations policies and procedures are developed and implemented by March 2020.
- Senior management must ensure that the audit tool based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed in a timely manner and that actions plans includes time frames and are followed up.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The senior operations management team must ensure that a single child safeguarding document is developed and that it is in line with statutory requirements, addresses the deficits found and that all staff then receive regular training on the updated document including relief staff members who have not received child protection training to date. The centre manager must ensure that a child protection register or log is kept to record and track child protection reports and that it is managed by the designated liaison person in line with their role and responsibilities.	It is envisaged that this review will be completed by the 14.2.2020. All staff will receive immediate training via their team meetings on a fortnightly basis commencing 25.02.20. New staff joining the organisation will receive training during their induction period. For a relief staff member who has been unable to attend a team meeting, training will be provided via the annual training plan which will be provided separately in a timely manner. The director of care and quality has devised a new register for same with immediate effect. This will be shared with all management teams at the next management meeting on the 27.1.2020.	The director of care and quality alongside the organisations training officer will add the child safeguarding document to the team's training schedule. To ensure that this document is reviewed regularly it will remain a permanent agenda item on the staff team meeting and the monthly management meeting. This will be reviewed by regional management as part of their governance to the centre. It will also be reviewed by the internal auditor. Any issues with same will be raised to the director of care and quality.
5	The director of care must ensure that	This piece of work is currently on going	A subcommittee has been formed to ensure

	the organisations policies and procedures are developed and implemented by March 2020. Senior management must ensure that the audit tool based on the National Standards for Children's Residential Centres, 2018 (HIQA) is developed in a timely manner and that actions plans include time frames and are followed up.	and as advised it is envisaged that it will be completed by March 2020 The internal auditor, regional managers, director of care and a manager from each of the homes are receiving external training on the 24.2.2020 in respect of the new standards and auditing of same. On completion off this senior management will have the audit template reviewed and updated by 13.03.2020. Time frames will be included in action plans that will be followed up.	that policy & procedures are regularly reviewed. This also forms part of the agenda for monthly governance meetings Regional management and the director of care will meet with the internal auditor on a regular basis to ensure that audits inform improvements in practice. The internal auditor will also attend the monthly management meeting, for any clarification/guidance required. All action plans will be reviewed within this forum to ensure that all actions have been followed up on.