An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 178

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ireland**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**12th, 15th, 23rd and 29th of November 2021**
Registration Status:	**Registered from the 22nd September 2020 to the 22nd September 2023**
Inspection Team:	**Linda McGuinness** **Sinead Tierney**
Date Report Issued:	**16th February 2022**

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 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 22nd of September 2020. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from the 22nd of September 2020 to the 22nd of September 2023.

The centre was registered to provide specialist therapeutic care and accommodation on a medium to long term basis to two young people of both genders from age 11 to 16 years on admission up to 18 years of age. The organisation had developed their own model of care based on six principles. It was primarily attachment and trauma informed with an emphasis on relationships, reflective practice and involving families. It was a strengths-based approach with a focus on the importance of routine and environment. There were two 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: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

At the time of this inspection the centre was registered the 22nd of September 2020 to the 22nd of September 2023. This is a draft report and the decision regarding the continued registration status of the centre is pending.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 15th of December 2021. 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 January 2022. Inspectors found that non regulatory compliance was found at the time of inspection but based on the review of CAPA these have been addressed and the regulation is deemed to be met.

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: 178 without attached conditions from the 22nd September 2020 to the 22nd September 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17 Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

The organisation had developed policies and procedures in place to support effective planning. Inspectors found deficits in the process relating to care planning, as an escalation process was not followed in situations where care planning documents were not provided, or inaccurate information was included.

The statutory care plan on file for one young person placed in the centre in March 2021 was dated May 2020 and related to a previous placement. The child in care review meetings were taking place monthly 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*. Seven of these meetings took place however, there were only records of four of these on the young person's file and no updated statutory care plan to meet regulatory requirements was provided. The child in care review meetings generally focused on current issues at the time and inspectors found that there was not a comprehensive assessment of needs provided through the care plan as required. These deficits were not adequately identified through governance of the service or addressed with social work, and this is discussed further under standard 5.2 of this report.

Inspectors found that this young person had four changes of social worker in the seven months since their admission to the centre. Management and staff stated in interview that the young person expressed dissatisfaction about this and that they felt it had negatively impacted them. There was no record of a complaint relating to this issue on the young person's care file either directly to social work management or through the *Tell Us* complaints policy. The social work team leader informed inspectors they were aware of this issue, and they were holding the case at this time to carefully consider who would next be appointed to the young person.

The social work team leader acknowledged that the young person was experiencing a period of instability, but they felt that the management and team were working hard

to maintain the placement and address concerns identified in monthly planning meetings. Discussions were ongoing with the social work department to determine what extra supports might be required to support the placement and they were scheduled to attend the next planning meeting with the clinical team. They received copies of planning documents and risk assessments. Following some delays with notifications of significant events, the social work team informed inspectors they asked to also be contacted by telephone or email. They reported that this was taken on board, they were appraised of concerns in a timely manner and there was good communication and collaboration to support planning.

The other young person was placed from Northern Ireland and a Looked after Child (LAC) plan dated July 2021 was in place. The statutory review meeting for this young person was postponed twice and therefore slightly outside the required regulatory timeframes. The social worker informed inspectors that this was due to staffing shortages related to Covid 19 and that a date was set for December 2021.
There was evidence of good communication with the supervising social worker, and they generally visited the young person and met with the team monthly. From a review of care files, interviews with staff, management and the social worker it was evident that they were making progress through the course of their placement.

Neither young person living in the centre at the time of inspection had participated in their care plan reviews. Inspectors found that that they were prepared for the meetings and were supported by staff through individual and key work to have their views represented by others if they did not wish to attend. Narrative work was planned and ongoing to support both young people understand their care history and the purpose of their placements.

Inspectors found that the care plans documents in place did not adequately reflect the current views of the parents and the young people in relation to their care as required by national standards and this must be raised at planning meetings.

Inspectors met and spoke with one young person during the onsite inspection. They said they were happy and content in placement and were able to name staff that they trusted. Inspectors also observed child centred practice with both young people while on site.

Inspectors found from review of the placement planning policy that it was not consistently implemented or realised in practice. There were several planning documents on file for each young person. These included an Individual Development

plan (IDP), a therapeutic plan, an Individual Crisis Support Plan (ICSP) and an Absence Management Plan (AMP). Inspectors found that the IDP intended to describe the needs of young people and supports required to meet specific goals. They were prepared and updated in consultation with managers, staff and the clinical team at bi-monthly IDP meetings. During inspection, inspectors found that staff and management were not fully able to explain how placement planning operated in practice. There was confusion about the language of plans as inspectors found that the plans were interchangeably known as IDP's or Individual Placement Plans (IPP). Management and staff could not describe if these were the same or different processes. There was a lack of consistency in their implementation every two months which was the timeframe for review described to inspectors. Inspectors found that information was repeated across plans possibly using copy and paste and some information that was no longer relevant was still included on current plans.

The plans covered aspects of the young person's development and tasks were documented into a monthly calendar with staff assigned to address specific issues. A review of both young people's files found that there was a lack of evidence that these tasks were followed through and reviewed. For example, in one case ten key working sessions were planned and only three took place. This was a pattern across each month in both young people's files. Inspectors also found that key working sometimes took place in a responsive way when young people instigated conversations but that at times planned sessions to meet specific needs did not happen or were not recorded. Placement planning deficits were not adequately addressed through auditing processes or governance of the service and there was no evidence that it was highlighted at IDP review meetings.

Inspectors found that generally, team meetings had a focus on current issues and challenges rather than a focus on review of goals and progress through placement planning. This resulted in reactive work being prioritised over proactive work in line with overarching goals of placements. Also, there was a lack of evidence that placement planning and key work tasks were effectively reviewed within the supervision forum. At the time of inspection staff had not been held accountable for work assigned to them but they had not completed.

Inspectors found that other planning documents required review to ensure they were implemented effectively. The Individual Crisis Support Plan ICSP for one young person was not updated and therefore not congruent with a decision made at a significant event review group about the use of physical interventions. The safety

concerns and warnings were not in line with the model of behaviour management in use and interventions stated on one ICSP were unlikely to be able to be used safely. Inspectors note that the issue of identification and implementation of specific goals arose in another recent inspection within the organisation. The registered provider must ensure that all actions requiring attention following inspection processes are promptly attended to and if relevant, implemented across the organisation.

While parents who were involved in the care of their child were updated regularly about progress, evidence of their input in placement planning could be improved and further developed.

Inspectors found from a review of daily logs and young people's meetings that they were encouraged to express their views and opinions, however more evidence was required to show that they were provided with opportunities to participate in a meaningful way to placement planning.

The young people had access to a range of supports through the organisation such as, psychological support, occupational therapy and art psychotherapy. Neither of the young people was engaging in direct therapy at the time of inspection but clinical input to support the staff team was evident across care files, centre records and the therapeutic plan.

The clinical team were usually available to staff members for consultation to support them and guide their work with young people although this was reduced until vacancies in occupational therapy and psychology were filled. Each young person had an Individual Therapeutic Plan (ITP) on file that provided practical guidance to approaches to care. Inspectors found that the clinical team was involved in planning and review and supplementary strategy meetings took place as required with the input of social work teams where young people's need were flagged as red or amber.

Compliance with regulations	
Regulation met	**Regulation 17**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed**
Practices met the required standard in some respects only	**Standard 2.2**
Practices did not meet the required standard	**Not all standards were assessed**

Actions required

- The registered provider must ensure that deficits in care planning are promptly identified and escalated appropriately for timely action with each social work department to ensure regulatory compliance.
- The centre manager must ensure that when young people express dissatisfaction about social work provision that their complaints are directed through the appropriate channels.
- The registered provider must ensure that the placement planning process is reviewed and that all staff are clear on the policy and procedure. Each placement plan must outline the needs and supports required and that actions, persons responsible and outcomes are reviewed.
- The centre manger must ensure that the input of young people and parents into placement plans is improved and evidenced across centre records.
- The registered provider must ensure that placement planning deficits are promptly identified through robust governance of the centre. Staff must be held accountable for work assigned but not completed.
- The centre manager must ensure that implementation of placement plan goals and tasks are discussed and reviewed at team meetings and in the supervision forum.
- The centre manager must ensure that each Individual Crisis Support Plan ICSP is up to date and contains relevant safety warnings/concerns

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

Findings across the standards reviewed for this inspection found that leadership governance and oversight required improvement to ensure child centred safe and effective care. Inspectors found that the organisation had governance arrangements and management structures which defined lines of authority and accountability. Not all these arrangements were understood by management and staff with some being unable to describe the roles of some people outside the centre. While governance and senior management meetings took place there were significant deficits in respect of auditing service provision and compliance with the requirements of national standards with appropriate follow up. The systems in place were not leading to service improvement.

Each staff member had a job description appropriate to their role. There was evidence of an induction process and a senior practitioner development programme.

There was a change of manager in the centre since it was registered in September 2020. The new manager commenced in post in September 2021. They held an appropriate qualification and experience for the position. They were the named person in charge and held the overall executive accountability for the delivery of service. Inspectors found they did not receive a comprehensive induction to the role and their responsibilities as person in charge. A period of transition took place while the previous centre manager was still there, and they were provided with policies and procedures. They had not received training in the model of care at the time of inspection and inspectors found that many of their responsibilities and operations of the centre were being taught to the centre manager by the deputy social care manager. It was the manager's responsibility to conduct audits against the National Standards and to report to senior management and the compliance officer. They were not fully clear about these processes and had not been provided with clear guidance and direction regarding many aspects of their role.

A review of minutes of team meetings and supervision records demonstrated that the centre manager was supportive of the team on a day-to-day basis. They were based in the centre Monday to Friday and regularly attended handover meetings.
They compiled an operations report for the director of care & quality, HR, operations manager and the regional management team on a weekly basis. This included information relating to young people's planning documents, supervision, team meetings, health and safety, complaints and staffing.

The findings of this inspection note that effective leadership requires holding staff accountable for their work and this was not fully in place at the time of inspection as noted in respect of placement planning and key working.

Throughout 2021 a range of audits had been completed to assess compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). This was essentially a self-audit process and there was no evidence of oversight, quality assurance, or verification of the information provided. Inspectors reviewed an audit of Theme 2 of the National Standards which was completed in April 2021. This audit was not effective in identifying the deficits observed in care planning noted under standard 2.2 in this report. There was a lack of evidence that learning from audits was discussed at team and management meetings and the centre manager was not clear about the process in interview.

Inspectors found that there were some deficits in the organisational management structure was no longer appropriate to the size of the organisation and recent expansion. The person in the role of compliance officer had not been in the centre since the last inspection in March 2021. In interview, they stated that due to organisational expansion and having multiple responsibilities they did not have capacity to fulfil the role as intended. Inspectors were informed that the post of another auditor had been approved. The compliance officer compiled an annual review of compliance in September 2020. Inspectors found this was a basic report based on information provided in self-audits without verification. Further, this report showed that there was no internal review or no quality improvement plans arising from the audits.

A small number of issues were noted on the annual review as being sent on to the governance meeting, some of which were identified through inspections. Inspectors found that all areas of non-compliance were not captured through audits or annual review. For example, from review of centre documents and inspection interviews it was determined that the centre was not adequately recording and tracking

complaints made by young people. Also, the system for review of significant events (SERG) was not working in practice. Learning outcomes and guidance following review of incidents was not recorded in management and team meetings in a way that would inform future practice. They had not taken place for some serious incidents. Further, and a root cause analysis of a specific incident was completed in July 2021, but the findings had still not been recorded and disseminated by the time of inspection in November 2021.

Inspectors also found that improvements were required in relation to organisational learning to ensure safe and effective care. The response to an unauthorised visitor staying overnight in this centre did not result in a prompt review and action plan across the organisation and the issue subsequently arose in another centre.

Issues relating to centre management knowledge of the auditing system, how compliance was determined, and service improvement/action plans arose in other inspections across this organisation and have not yet been adequately addressed. A previous inspection report from an inspection in May 2021 required implementation of adequate and robust assessment of the safety and quality of care provided as measured against the National Standards for Children's Residential Centres, 2018 (HIQA). This remains outstanding.

The regional manager acknowledged these deficits and reported that the organisation was undergoing a process of change which involved an external consultant and a review of policies, processes, recording and governance. This had commenced, however there was no definitive timeframe for completion.

The regional manager often attended handover meetings and spent time observing practice when they visited the centre and the centre manager reported that they were a good support to them and the team. They provided a record of their visits to the centre and any guidance and support provided. There was also evidence that young people were familiar with them, and they met with them while on site.

The organisation was contracted to provide a service to the Child and Family Agency through Tusla's national private placement team (NPPT). They provided the funding body with progress reports and updates regarding young people's placements.

The inspectors found that there was an appropriate management structure in place within the centre. The deputy manager supported the centre manager, and both

worked office hours Monday to Friday. There was also a senior practitioner who worked on the rota to provide support and guidance to the social care workers.

The inspectors found that policies and procedures were updated by a dedicated sub-committee. Inspectors concur with the findings of other inspections across the organisation that policies required review to more effectively guide practice and be fully aligned with the requirements of national standards. Examples of this were policies relating to governance, care planning, placement planning and review of significant events. The policy relating to retention of information must be reviewed to ensure compliance with GDPR, in that no identifying information relating to young people is held on other young people's files as this was found during the onsite inspection. The policy relating to recruitment did not include the requirement for international police vetting.

Staff confirmed they had reviewed specific policies at their team meetings however this should be more effectively recorded.

There was a risk management policy and framework in place. Staff interviewed outlined the systems in place for measuring risk, and the strategies in place to manage individual risks associated with young people's presentation. There were risk assessments regarding daily activities and staff had appropriate strategies in place to manage some risks associated with group living. These were updated as required. Inspectors found however, some risks such as bullying or sexualised behaviour were not appropriately identified with a risk assessment and entry on to the risk register. Also, some information known at referral stage was not included sufficiently in the pre-admission risk assessment. Inspectors found that a social worker for one young person had raised concerns at the referral stage of another admission. There was no evidence that they received a written response or that a meeting took place to consider their concerns. The risk register did not include the impact of having no dedicated relief staff or staff leaving because of challenging behaviour and assaults.

Inspectors found that the risks associated with the Covid-19 pandemic were well managed across the organisation. There was prompt and regular access to personal protective equipment, cleaning materials and sanitiser. Staff received training relating to Covid-19 and policies and protocols were reviewed in line with guidance and advice from the National Public Health Emergency Team and government guidelines.

There were appropriate arrangements in place to provide cover when the manager took periods of leave.

A formal record of management tasks that were delegated to appropriately qualified staff members was not yet in place as required. Inspectors were provided with a template for this post inspection.

Compliance with regulations	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5**

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

Actions required

- The registered provider must ensure that the governance arrangements and organisational structure is fully understood by all staff and managers.
- The registered provider must ensure that each centre manager is adequately inducted into their roles and responsibilities
- The registered provider must ensure that all actions requiring attention following inspection processes are promptly attended to and if relevant, implemented across the organisation.
- The registered provider must ensure that there is a robust auditing process and follow up in place to benchmark quality and safety of care provided against the National Standards for Children's Residential Centres, 2018 (HIQA). There must be evidence that governance and oversight results in service improvements.
- The registered provider must ensure that the management structure is appropriate to the size of the organisation and recent expansion.
- The registered provider must ensure that there is an effective system in place for the review of and learning from significant events, serious incidents to inform policy development and future practice
- The registered provider must ensure policies in place appropriately guide practice and support compliance with the requirements of the National Standards for Children's Residential Centre's 2018 (HIQA).

- The centre manager must ensure that all risks are appropriately identified, recorded and managed.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

There was evidence of workforce planning through management and team meetings and in regional manager records. The staff rosters were planned in advance to incorporate annual and other types of leave.

Inspectors found that the team was supported on a day-to-day basis to deliver child-centred care. Inspectors found from review of the records that some staff struggled to understand and manage behaviours of one young person. There was evidence that the social care manager was encouraging them to understand the causes of challenging behaviour and to reflect that it was related to trauma, attachment and clinically diagnosed presentation. Some records reviewed indicated that the team needed more support in this area and had requested specific training to support them with behaviours relating to the diagnosis. The regional manager had also recognised that this training was required, and it was noted in records in July 2021. This training was still outstanding at the time of inspection in November 2021. The registered provider must ensure that staff are provided with training in a timely manner to develop the skills and competencies to meet the needs of young people. Some other core training had been delayed due to Covid 19 and was being rescheduled at the time of inspection.

In general, staff members were appropriately qualified in social care or a relevant field. A sample of personnel files reviewed by the inspectors found that, apart from the social care manager qualifications were on file and verbally verified as required. There was evidence that the manager was on the register of professionally qualified social workers, but no qualification was on file, and this must be provided. References provided did not always come from an official email account to ensure the veracity of the correspondence – this must be addressed by the organisation.

There were eight full time social care staff, including two senior practitioners plus two staff working reduced hours on the core team. There was a pattern of very challenging behaviour and assaults on staff in recent months but there was no evidence that this was considered in terms of staff retention.

The previous social care manager and three staff left their posts since the last inspection in March 2021. These positions were filled in a timely manner. Inspectors found that while it appeared that there were sufficient staff to fulfil the purpose and function and meet the needs of young people, the social care manager and deputy manager were often providing support on the floor to manage difficult situations with one young person. This was partly due to the dysregulated behaviour, but inspectors found that the limited social care experience on the staff team also contributed. The ratio of staff to young person should be considered with the social work department to ensure that safe effective care is always provided

The centre did not have dedicated relief staff and the manager and deputy manager had regularly covered support shifts and sleepover duties. This led to a situation where those in management were removed from their primary functions to support the day to day running of the centre. There was no evidence that these issues were identified as a risk, discussed at recent governance meetings or entered on the risk register. The registered provider must ensure that there are sufficient core staff to meet the needs of children living in the centre. There must be sufficient relief staff available who are familiar to the young people to cover all types of staff leave.

At the time of inspection two staff members worked a 24-hour shift and slept overnight in the centre and a third staff provided a support shift from 10 am to 8pm. Inspectors recommend review of the support shift ending at 8pm to ensure that the rota meets the needs of the current group of young people and provides safe care. It was normal practice that some staff completed back-to-back shifts and then went on to do a follow-on day shift on top of their 24-hour duty. This decision was based on expediency and the home locations of staff and not the needs of the service. There was no evidence of assessment of risks associated with this decision. Inspectors found that the needs of the current group of young people were high, and that back-to-back staffing was not safe practice and must cease.

Staff retention measures such as supervision, career development opportunities, incremental pay scales, pension contributions and maternity leave were in place. Annual appraisals had not been taking place in line with policy. This was significant

in terms of the challenging nature of the work, staff support, and staff retention and they must take place annually.

There was a formal on call policy and procedure in place as required.

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

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

Actions required

- The registered provider must ensure that the staffing ratio is risk assessed, considered with social workers and that there are sufficient staff to meet the needs of young people so that managers can attend to their primary responsibilities.
- The registered provider must ensure that qualifications are held on file for all staff and managers.
- The registered provider must ensure that staff are provided with training in a timely manner to develop the skills and competencies to meet the needs of young people.
- The registered provider must ensure that there are sufficient qualified and experienced relief staff available, who are familiar to the young people to cover all types of staff leave. Management must be available to attend to their primary functions and not be relied upon to cover staff deficits.
- The registered provider must ensure that the rota is primarily planned and configured to meet the needs of the service and specific needs of the young people.
- The registered provider must ensure that staff do not work back-to-back shifts.
- The registered provider must ensure that all risks relating to staffing are appropriately recorded, managed and reviewed within the risk management framework.

. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered provider must ensure that deficits in care planning are promptly identified and escalated appropriately for timely action with each social work department to ensure regulatory compliance. The centre manager must ensure that when young people express dissatisfaction about social work provision that their complaints are directed through the appropriate channels.	With immediate effect. Regional managers will now review care plans, as part of their key task list at each monthly visit to the home in conjunction with the home managers to ensure deficits are promptly identified and corrected. With immediate effect. The home manager will advocate on the young people's behalf and initiate a formal complaint if a young person expresses dissatisfaction with their social work provision.	The subcommittee policy review group will devise an escalation policy to ensure prompt action occurs to ensure there are no deficits. in care planning and to ensure regulatory compliance. This policy will be presented to the governance committee on the 27.1.2022 for ratification. Following same it will be circulated to all teams for implementation. All young people will be made aware of the 'Tell Us' Portal via the young people's handbook. This will be kept as a regular item of key work. The complaints policy will be reviewed with the staff team on 12.1.2022 and a review will also take place for the young people at the next young person's meeting.

	The registered provider must ensure that the placement planning process is reviewed and that all staff are clear on the policy and procedure. Each placement plan must outline the needs and supports required and that actions, persons responsible and outcomes are reviewed.	A review is actively underway at present - The organisation is currently undertaking a complete overview of the placement planning process to ensure the placement plans outline the needs and supports of the young people are met and there is clear guidance on accountability and responsibility from the overall team. A new suite of documents has been devised with collaboration from operations and the clinical team to ensure that robust mechanisms are in place for placement planning. We expect this new recording format to be in operation within the next 6-8 weeks.	This will be reviewed regularly as outlined in policy to ensure outcomes are being met and continue to be in line with the agreed placement plan and overall care plan. The management team will ensure that all staff are clear on the policy and procedure re placement planning process via team meetings and supervision.
	The centre manger must ensure that the input of young people and parents into placement plans is improved and evidenced across centre records.	With immediate effect. The centre manager will ensure all young people have an input into their placement plans via the key work process. Placement plans will be shared with parents, via the young people's social work departments or directly with parents where appropriate.	The multi agency planning (MAP) meeting has been reintroduced and will be completed with the young people in January 2022 to ensure their voice is captured in relation to their overall placement and these will be held on file. This will be an ongoing process with the young people. Parents will also be provided with a parents feedback form at regular intervals

		Centre management will ensure that that any input from parents is recorded appropriately and this information is shared with social work departments via monthly summaries and review meetings.	throughout a year, for feedback to be sought.
	The registered provider must ensure that placement planning deficits are promptly identified through robust governance of the centre. Staff must be held accountable for work assigned but not completed.	The current review of the placement planning will take into account deficits and will place a strong emphasis on accountability and responsibility. Any deficits will be promptly reported to the regional manager via a weekly operations report or escalated sooner if required. With immediate effect all staff had been issued with clear communication in respect of expectations and accountability.	Placement planning will be reviewed regularly in a multi-disciplinary setting to ensure there is robust governance. They will also be reviewed via home managers and compliance officer audits within the home. Social workers will be invited to attend placement planning meetings to provide external oversite and governance.
	The centre manager must ensure that implementation of placement plan goals and tasks are discussed and reviewed at team meetings and in the supervision forum.	With immediate effect. The centre manager will ensure these are a permanent item on the agenda of both team meetings and supervision. By reviewing the implementation of same monthly will ensure robust oversight internally by the management team.	The regional manager will complete spot checks during their monthly visit to the home on team meetings and supervision records to ensure placement goals are being discussed and reviewed. These will also be audited via the compliance officer as part of their auditing plan for 2022.

	The centre manager must ensure that each Individual Crisis Support Plan ICSP is up to date and contains relevant safety warnings/concerns	With immediate effect. The centre manager will ensure there is comprehensive review of the ICSP and ensure it contains relevant safety warnings and concerns. The centre management will be supported by the lead behaviour management co-ordinator in completion of same.	ICSP's will be reviewed in conjunction with the behaviour management team/SEN team on a more formalised regular basis. This will ensure that the information contained in the document is factual and relevant and in line with the current version 7 of the behaviour management programme. As the organisation has now grown with a greater number of behaviour management trainers, this home will have an identified trainer who will also review and audit the home ICSP's on a regular basis.
5	The registered provider must ensure that the governance arrangements and organisational structure is fully understood by all staff and managers.	With immediate effect. The organisation will ensure all staff are aware of the governance arrangements and the organisational structure. This will be discussed via team meetings for staff and management meetings for managers.	Going forward an overview of the governance and organisational structure will be provided to all staff during the induction process. This will in turn be reiterated to any new staff via the supervision process and any updates/changes to governance arrangements/organisational structure will be communicated to staff via team meetings or memo circulation from senior management where appropriate.

	The registered provider must ensure that each centre manager is adequately inducted into their roles and responsibilities	With immediate effect. A very clear robust induction programme is currently being devised by the training team for new managers regardless of whether they are external or internal candidates. Within this process new managers will be afforded additional support and supervision via their regional manager throughout their probation period.	The Director of Care & Quality alongside the regional team will ensure that no new appointments are made until they are satisfied that new managers have been fully inducted and that their induction period is signed off by a regional manager.
	The registered provider must ensure that all actions requiring attention following inspection processes are promptly attended to and if relevant, implemented across the organisation.	With immediate effect. The organisation has recently reviewed this process and there is a new structure in place to implement corrective actions across the organisation in a timely manner.	As part of a regional manager's new key task list, CAPAs will be reviewed by regional managers during their monthly visits to ensure home managers are implementing same. Any deficits to implementation will be captured more promptly.
	The registered provider must ensure that there is a robust auditing process and follow up in place to benchmark quality and safety of care provided against the National Standards	The organisation is currently in a process of a large review of the auditing process and will be introducing a specific auditing system early in 2022. (Expected date of implementation is now 8 – 10 weeks from completion) The management structure	The new Vi clarity system in conjunction with the recruitment of a second compliance officer will ensure there is a robust auditing system in place across the organisation. This new process allows for a programme of auditing which will track internal audits and

	for Children's Residential Centres, 2018 (HIQA). There must be evidence that governance and oversight results in service improvements.	will also be reviewed to meet the demands of the organisation given its current size and future development. All areas for oversight and service improvement will be raised to the governance committee for implementation of same.	external audits. It will also allow for not only a more comprehensive review by the auditing team as it grows in size but both the regional team and the Director of Care & Quality will have access to the system for an extra layer of governance.
	The registered provider must ensure that the management structure is appropriate to the size of the organisation and recent expansion.	This is an ongoing process. As part of the leaderships weekly meeting, we now are reviewing any gaps in service appointments and discussing time frames for additional resources/new appointments.	As part of governance oversight any gaps in extra personnel to appointments will be highlighted through this forum by each department. The Director of Care & Quality will in turn ensure that this is brought to the attention of the leadership team and escalated to the Board if required.
	The registered provider must ensure that there is an effective system in place for the review of and learning from significant events, serious incidents to inform policy development and future practice	Currently underway - The organisation is currently reviewing the significant events review process. This overhaul will encompass a review of learnings from significant events and how this impacts policy and learning for the overall company. A new policy has been devised in accordance with the new system proposed and this will be circulated to all	The review will initiate a triage process and return the focus and accountability of SERGS to the home managers in the first instance. The aim is to capture immediate learnings from significant events in order to improve service delivery. As part of this review the organisation has noted that we were reviewing a vast quantity of SENs as opposed to a quality process of

		staff and management teams once this new system is digital. (Approximate time frame is 6-8 weeks)	review and learnings. By changing the structure to meeting once a month as a comprehensive review process with the SEN team/Regional Management/Clinical Team/Home Management/SW department, this will allow for clearer oversight which will inform policy development as required.
	The registered provider must ensure policies in place appropriately guide practice and support compliance with the requirements of the National Standards for Children's Residential Centre's 2018 (HIQA).	The organisation has a full set of functional policies and procedures. As with each inspection that takes place throughout the organisation, these will be reviewed on a regular basis to ensure updates and ensure that guidance from ACIMS has been implemented. The policy & procedure subcommittee are meeting on the 11.2.2022 for a full day to review the current set of policies and highlight those that need brought into line with immediate effect. The risk management framework will be operational by the 1.3.2022 and the new auditing system in place by the 1.4.2022. A full review of all policy and procedures will be completed by the 30.6.2022. to ensure a robust review.	As part of monthly management support meetings, home management teams will highlight in this forum if there are any policies which require an update. The regional team will forward same to the subcommittee of the policy & procedure group, who will meet monthly to review same. The governance committee also meet monthly, and policies are ratified at this committee and also recommendations are given for policies which require review.

	The centre manager must ensure that all risks are appropriately identified, recorded and managed.	The organisation has reviewed the current risk management reporting and is implementing a new system. The training for this will begin in Jan 2022 and the subsequent roll out of the new risk management framework. This will be supported by the relevant policy to guide this practice.	There will be a regular review of the new risk management framework to ensure this new system is effective in guidance practice and ensuring all risks are appropriately identified, recorded and managed. The consultant brought on board to conduct this review will be ensuring that they deliver the training on the new system across the organisation to ensure consistency across the organisation. The risk management framework will be reviewed regularly by the regional team going forward following implementation to ensure this new system is effective and guides the practice of staff.
6	The registered provider must ensure that the staffing ratio is risk assessed, considered with social workers and that there are sufficient staff to meet the needs of young people so that managers can attend to their primary responsibilities.	With immediate effect. The organisation is undertaking an intensive recruitment strategy to recruit suitably qualified staff in line with the memo from ACIMS, February 2020 to ensure that there is always the appropriate ratio of staff for the home, to ensure that the management team do not have to fulfil any staffing deficits.	Work force planning meetings alongside HR and the regional management team will occur on a weekly/monthly as required to determine where the risks are in relation to staffing and determine how best to support the home.

	The registered provider must ensure that qualifications are held on file for all staff and managers.	The organisation will ensure the HR department take immediate corrective action to ensure all qualification for staff and management are held on file.	Newly recruited staff and managers will not commence employment in the homes until all relevant documentation has been received and is on file. Checks and balances will also be conducted by home management and the regional management to ensure that they have signed off on a staff members personnel file and are satisfied with the content of same.
	The registered provider must ensure that staff are provided with training in a timely manner to develop the skills and competencies to meet the needs of young people.	With immediate effect. All training within the organisation has been reviewed and the training team will provide training in a timely manner to develop the skills and competencies of the staff. ASD training for the team has been scheduled for January 2022.	From January 2022 management teams will receive a monthly report from the training department outlining a training schedule for their teams and what training is currently completed/still required. All managers are aware of how to escalate training needs and how to request bespoke training for their home.
	The registered provider must ensure that there are sufficient qualified and experienced relief staff available, who are familiar to the young people to cover all types of staff leave.	Recruitment is ongoing - The organisation will ensure the recruitment process includes recruiting relief staff specific to individual homes to promote consistency and ensure the relief staff are familiar to the young people.	Each home will have a specific number of relief staff assigned to them. These staff will be directly line managed by the home management team to ensure consistency and stability within the staff team.

	Management must be available to attend to their primary functions and not be relied upon to cover staff deficits. The registered provider must ensure that the rota is primarily planned and configured to meet the needs of the service and specific needs of the young people. The registered provider must ensure that staff do not work back-to-back shifts.	 The organisation, in conjunction with the manager are in discussions with the social work department for one young person in relation to an additional staffing request to better meet this young person's needs. This practice of back-to-back shifts known as LLE's or LE/S in this home will now cease.	 Going forward home management along regional management will review the homes rota before it is published to staff to ensure that it meets the needs of the young people. Any deficits in same are to be highlighted to the workforce planning group with immediate effect, and a clear plan is to be implemented to support the rota structure. Following consultation with registration and inspection, clarification was sought in respect of same. Liaison was then conducted with our HR department and Regional Team on the matter. Going forward the regional team must be informed if this practice is to occur e.g., as part of covid contingency planning. The practice of including these shifts on rotas will now cease and home management and the HR department will speak to staff who have

			specifically requested these shifts within their working contract. Any concerns going forward in relation to shift patterns are to be flagged directly to the regional manager. The home risk register will be regularly audited by the regional manager, who will in turn escalate any areas of concern to senior management, if corrective actions are not implemented in a timely manner.
	The registered provider must ensure that all risks relating to staffing are appropriately recorded, managed and reviewed within the risk management framework.	With immediate effect. The organisation via the regional manager will ensure that collaboration is conducted alongside the home management team to ensure the Home Risk Register is updated to reflect all risks relating to staffing are clearly documented.	