An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 160

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Four**
Type of Inspection:	**Announced**
Date of inspection:	**18th & 19th February 2020**
Registration Status:	**Registered without attached conditions from the 30th of August 2019 to the 30th of August 2022**
Inspection Team:	**Eileen Woods** **Cora Kelly**
Date Report Issued:	**27th May 2020**

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 30th of August 2019. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from the 30th of August 2019 to the 30th of August 2022.

The centre was registered to provide specialist medium to long term care for up to four young people aged from ten years old to fourteen years old upon admission. The model of care was a clinically guided person centred therapeutic care model for young people experiencing complex emotional and behavioural problems. There was one young person living in the centre at the time of the inspection.

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 on the 20th of April 2020 and to the relevant social work department on the 20th of April 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 8th of May 2020. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 160 without attached conditions from the 30th August 2019 to the 30th of August 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

The practices at the centre were found to be compliant with the relevant policies as outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017 and the relevant legislation. The policy document was not fully reflective of them as yet. The registered provider through their line management structures, policy and training departments provided guidance, policy and procedure updates and made training available relevant to child safeguarding and child protection. The team's knowledge regarding the fullest extent of Children First and their role in it came from their internal training and their completion of the relevant national training module. The centre had their child safeguarding statement in place as required by regulation, the statement had been reviewed and approved by the Tusla child safeguarding statement compliance unit and was displayed in the staff office.

The policies and procedures in place were not fully in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the relevant Children First Act 2015. The policies, inspectors were informed were under review and nearing completion. The director of care and quality outlined that they were clear regarding the changes required to fully update the policy. The existing policies did address forms of abuse and neglect and how to minimise its effects through specific centre based responses and supports.

The centre had a policy and procedure in place dealing with anti bullying. The policy cross referenced the child protection policy and the children's right to complain should they experience bullying. Some elements of the policy required an update to deal with staff and visitors to the centre and to expand more regarding social media.

Inspectors found that the staff interviewed as part of this inspection had good knowledge of safeguarding and child protection. Staff had completed training in the Tusla E-Learning module: Introduction to Children First, 2017 and had company training in child protection and safeguarding policy and procedures. Their knowledge during interview exceeded that described in their existing policy, for

example the role of mandated persons and what categories of staff hold that role. As stated the company policy covered prevention, detection and response to abuse. There was also company training available in safeguarding and a number of the team had completed this.

This was a newly opened centre with one young person residing and inspectors found good evidence of collaborative work with the social worker and the family of the young person. It was recorded that staff took opportunities to discuss plans with the young person, sought their views and supported them in understanding what was happening around them and their plan.

There was evidence that staff completed key work and individual work getting to know the young person, identifying their strengths, needs and vulnerabilities. The work of the team was paced in accordance with the young person's needs and willingness to engage. The areas of safeguarding that needed to be addressed had been discussed with the young person, their family and their social work department and risk management plans put in place. The plan was co-ordinated to include the agreement of the young person, their family and all professionals.

The young person was aware that designated members of their family were informed of incidents and would be informed of any allegations of abuse as appropriate. Inspectors were provided with a copy of a young person's booklet that was significantly out of date regarding the references in it. As an essential part of communication mechanisms with children this must be updated and be in line with the National Standards for Children's Residential Centres, 2018 (HIQA) which gives specific guidance on communication with children.

There was an appropriate policy and procedure in place on protected disclosures. The policy had been circulated to all staff and followed up by the manager to ensure the team knew and understood the policy and procedure in place on protected disclosures. Inspectors found that staff had a good understanding of who to report to should the occasion arise.

Standard 3.2

This centre's staff team had trained in an evidence based model of care that incorporated a responsive, needs led and positive care approach. The staff's use of language was child centred and solution focused in key working. The model of care incorporated an attachment and trauma informed model to meet complex emotional

needs supported by a specialist therapeutic team with a goal they identified as maximising potential through positive engagement. The team were trained and inducted in the centre's approach and received ongoing training and support through a training and awareness programme and through the monthly meetings with the specialist therapeutic team. The team were also trained in an evidence based, researched and recognised model of management of crisis behaviours.

There were schedules of training for all staff in the model of care, the recognised model of management of crisis behaviours and specialised aspects of care for complex young people. All of the training was co-ordinated at the centre by the manager through a central training stream and was overseen by an external senior manager. The training was focused to support staff to build awareness and skills to respond effectively to behaviours that challenge and to be reflective and informed in how they consider the underlying drivers for behaviours. The centre manager maintained an up to date training record for all staff and their role was to also request suitable additional internal training if identified as necessary. There was a specialist multidisciplinary therapeutic team in place who met with the team on a monthly basis to review the plans for the young person and to advise the team. Social workers, other professionals and family members could be invited to attend and participate in these.

There were plans and profiles on file that looked at the underlying drivers, triggers and causes of behaviours that challenge. The team displayed that their practice took account of the impact of environment, mental health and loss on young people. There were records in key working, one to one work, individual placement plans, risk management plans and individual absence management plans that the team were implementing their training and seeking to build relationship and trust with the young person.

The young person's file contained evidence of work being commenced with them around their own understanding of their situation, what has worked or not for them in the recent past and how to move forward with staff support. Inspectors found that the tone established by staff was respectful and positive. An aspect that had yet to be implemented in practice with the young person was a collaborative outcome measurement tool put in place by the company as part of their expanded model of care.

The staff had background information in place from the social worker and other professionals, the latter contributed information regarding challenging behaviours

and incident management. Contact was made with the family and the young person before admission and the admission procedures were followed. An initial assessment of need was commenced in accordance with the company's shared admission and planning processes.

The registered provider through their director of care and quality and the senior management, therapeutic and education teams resourced and supported a training and development culture and a responsive environment which takes prominent account of the promotion of positive change and measureable outcomes as goals in young people's care. The training programmes, facilities, personnel and policies all included guidelines in managing behaviours that challenge. There was evidence of auditing having been commenced for this new centre and that auditing took account, as part of its structure, of behaviour management. The auditing system had not yet been aligned to specific criteria contained within the National Standards for Children's Residential Centres, 2018 (HIQA). The registered proprietors had a dedicated compliance officer in post and as part of their governance sought feedback on outcomes and from young people and aimed to increase the integration of feedback from young people in the organisation.

There was a restrictive practice policy and procedure in place which inspectors found required review in order to bring it in line with the national standards. The procedure identified that restrictive practice should only be engaged in if all alternative procedures had not been successful in alleviating the child or young person's behaviour. It also identified that the least restrictive means for the shortest duration should also be applied. The procedure allowed for a review after its use and risk assessment where possible prior to engagement in it. The policy listed moving a child and locking of exit routes in a crisis and this must be reviewed from a rights based perspective and the focus moved to use of preventative measures, alternatives and to include a wider, rights based understanding of what constitutes a restrictive practice. These should be logged, tracked and audited where they occur.

Standard 3.3

Inspectors found that the manager was promoting an open culture with staff and young people through regular supervision, informal supervision, and awareness of whistle blowing, seeking through these to establish a mutual support and learning culture. There was evidence from staff that they felt that they could and would raise concerns but had not encountered this as yet. There was evidence that the young person spoke to staff and that they acted on matters that caused concern. An example of this was that the young person noted their dissatisfaction that staff from

the centre were assisting at other busier centres and the manager acted on this and ceased this activity.

On a day to day basis there were mechanisms for contact with family and with professionals including the social worker to discuss issues, incidents and their outcomes. An overarching method of collating and responding to feedback had not been implemented, inspectors were informed that the development of same was being completed. There was collaborative planning and review evidenced also. The registered proprietor through their director of care and quality and senior team stated their goal was to increase their mechanisms for gathering feedback and using that information to inform development in line with the national standards.

There were a range of cross referenced policies and procedures in place for the notification, management and review of incidents. These included policies on significant events, unauthorised absences, engaging with the Gardaí and others. The procedural guidelines in these were clear and comprehensive including the role of senior operational line management. The policies as presented were in line with relevant regulations and national policy.

The manager of the centre was the named person in charge and Inspectors found that they oversaw incident reporting at the centre and provided guidance and feedback to staff. Inspectors found that incidents were reported in a timely manner and were of a good standard.

The director of services had in place a regional manager structure with clear procedures for oversight and governance for incident reporting and review. This happened at centre level through visits by and meeting with the regional manager and the centre manager, these were recorded. The regional manager reviewed records at the centre to independently satisfy themselves that policy, practice and learning outcomes were in place.

Externally the regional management and the clinical team leader received all incident reports and provided feedback to the centre where they identified the need. There was evidence that the incident reviews generated re-examination of plans and discussion with the young person, their family and social worker. There were significant review audit sheets, operational management meetings, governance committee meetings where the director and proprietor were updated. More critical incidents or cycles of incidents could trigger an internal case review and interventions such as additional training would be offered to a team.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The director of care and quality must ensure that the policy and procedure document is fully reviewed and fully reflective of the relevant legislation, national guidance and national standards with regard to child protection and safeguarding.
- The director of care and quality must ensure that the anti-bullying policy and procedure are reviewed and updated in line with the national standards, the relevant national guidance and the child safeguarding statement.
- The centre manager must organise for the centres booklet for young people to be improved and updated to be accurate and reflective of rights based, informative and consultation based approach in line with the national standards.
- The director of care and quality must ensure that the restrictive practices policy and procedure is reviewed and expanded taking account of the definition and criteria provided in the national standards.
- The centre manager and the director of care and quality must establish a system of recording, reviewing and auditing of restrictive practices.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The registered proprietor through their director of care and quality, operational regional management team and therapeutic team had a structure in place dedicated to ensuring good service delivery for children and young people in a manner that was in compliance with the requirements of relevant legislation, regulations and national

standards. Whilst operationally day to day the inspectors found this centre to be functioning well the company had yet to update a number of key policies fully in line with Children First and the national standards. They were also devising a full roll out of the auditing system in line with these also.

The director of quality and care met with inspectors and named that they were aware of residual gaps in their policy and centre recording systems and had plans in place to address these. Items identified by inspectors were known by the director through their own analysis and review in line with the relevant legislation, national policies and the national standards. They did not have a timeframe for completion of the items and inspectors advise that they create a structure for this in order to maintain a timely framework.

Staff at the centre, through their questionnaires, interviews and interaction with inspectors demonstrated their induction, training and team learning had given them a good knowledge in the relevant policies and regulations.

Standard 5.2

The centres internal leadership team consisted of an experienced manager who had been in charge of this centre since October 2019, it opened in August 2019 with the first admission taking place in October 2019 also. The manager was assisted by a deputy manager, both were suitably qualified for their role. Inspectors found that the manager had established a positive culture and that team morale was good. There was evidence of their leadership through daily presence, decision making, provision of supervision, holding team meetings, organisation of training, and oversight of all written work at the centre.

The internal and external management posts were outlined on an organisational map. There were job descriptions in place for all staff, they had received a copy and a copy was also maintained on their personnel file. There were clearly defined governance arrangements and structures that set out the lines of authority and accountability for the centre. There were named persons assigned to each role and the first line of operational contact for the centre was a regional manager who assumed direct line management responsibility for the centre. They oversaw the centre and reported to a senior manager. Inspectors found evidence of the roles of all personnel from director level to social care worker across the centre records and across the manager's governance records.

The director of care and quality informed inspectors that the centre did not, at that time, have a contract or service level agreement in place with the funding body Tusla, The Child and Family Agency, they did not satisfy the initial criteria for staffing as laid out in those agreements. The company did have an agreement with a health authority in Northern Ireland to facilitate the placement of a young person.

The director and the registered proprietor were in ongoing communication with the funding body Tusla and provided information relevant to staffing, governance and care practices.

The agreed person in charge was the centre manager and inspectors found that they had a sound understanding of this role and had systems and routines in place, in line with company policy, to execute that role. They were familiarising themselves with the national standards during their roll out in practice and had pre-existing knowledge of the relevant regulations.

The centre had access to a full set of relevant policies and procedures. These had been added to and developed by the senior team at regular intervals with the last date of review recorded on the document as being June 2019. In agreement with the director of care and quality it was named by inspectors that the child protection policy required additions and some clarifications as did the restrictive practice policy with some other adjustments required to bring the document aligned to the national standards. Inspectors found that the centre manager did not have a role in policy development and recommend that such a role be considered for managers from time to time within the organisation. It was also noted that a timeframe for completion of this review should be put in place.

There was a suitable risk management framework and set of procedures in place. There were supporting documents such as risk management plans and individual crisis management plans. These along with the individual development plans and the absence management plans were regularly reviewed in collaboration with the multidisciplinary therapeutic team. There were on-call rosters for senior support and there was advice and guidance available for staff. The staff on duty undertook situational risk assessments if required in the moment and referred to their existing risk management plans as appropriate to the situation. The team worked with risk and tried to maintain a quality of life for the young person that aimed to educate them on keeping themselves safe.

The manager and their deputy manager displayed good communication and co-operation in the execution of their roles, the staff spoke positively about their leadership. The regional manager supported and oversaw their work.

The deputy manager was the named person to act up for the manager when required. The manager and deputy maintained clear written records of their work and tasks undertaken. The distribution of tasks were named internally and agreed and overseen by the regional manager. There were management records, operations management visit records, supervisions and reporting procedures that recorded these tasks and activities including recording and circulating of decisions at all levels.

Standard 5.3

There was statement of purpose and function for the company that identified this centre as one of its residential centres and named that it provided a service for up to four children and young people with complex needs. It was updated in June 2019 and clearly described the model of service provision delivered by the company through its central hub. The aims, objectives and range of multidisciplinary therapeutic, educational, outdoor and clinical services it offered were well described. The statement did not list the management and staffing numbers for the centre whilst it did outline the senior team organisational structure of the company.

The statement of purpose was not well known by the team and it had not been focused on specifically with them as a core document. The manager was unsure if a copy had been sent to the family and to the social worker for the young person and the inspectors were unable to verify this independently. The young person's booklet provided to inspectors did not, upon review, reflect an up to date picture of the centre either and as stated must be reviewed also to ensure that each young person has a clear picture and information about the centre and its goals. A copy of the existing purpose and function was displayed and available for staff, the young person did not favour public display of documents and information.

The staff team did however understand and implement the model of care and were being trained in rotation in a further evolution of the model of care staying focused around trauma and attachment informed evidenced based models of care and intervention. They were aware of the initial goals for the young person and were working at the young person's pace.

The statement of purpose had been reviewed as stated in June 2019 and had not been benchmarked against the national standards as outlined in Theme 5. The centre had been internally audited but should now include evaluation through their quality assurance systems of the quality of the delivery of the purpose and function at centre level.

Standard 5.4

The company had been continuously improving the content and scope of their specialised care package for children and young people. They had done so based on their own internal review and assessment of outcomes for children and on demand for their services. This centre with its stated age range and capacity was opened as part of this development. The arrangements for oversight of the safety, well being and quality of care for the young people in this centre was overseen by the manager onward through the regional manager and into the senior management team and governance systems.

Inspectors found that there were a number of outcome measurement tools outlined in policy and procedures and that that these were not as yet in use on records at the centre. As these are part of the intended arrangements for assessing the effectiveness and suitability of interventions for young people these should be evident and implemented in accordance with the intended policies. The registered proprietor had a compliance officer in place and they maintained a schedule of themed audits both announced and unannounced, in the four months the centre had been operational in care delivery one formal audit had been completed, a report issued and responded to by the centre. The audit was conducted in line with the implementation of the Themes 3 and 5 of the National Standards for Children's Residential Centres, 2018 (HIQA). The audit was detailed and made recommendations for the centre and also for the senior management team. The manager completed monthly internal audits and these were found to be up to date and accurate.

The director of care and quality chairs a governance committee that was informed by the operational management meetings, audits and incident reviews, complaints and concerns. The director had visited the centre and met with the young person as part of the governance processes and there was a record on file of this visit and any outcomes from it. Items referred from the auditing and quality assurance process and the regional manager regarding matters to address or trends noted were evidenced on file at the centre.

The company produce annual reports and ongoing reports related to compliance, development and performance. They aim to include a dedicated annual review of compliance with their objectives per centre and any actions, improvements and developments that take place.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.2** **Regulation 6.1**
Regulation not met	**None identified**

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

Actions required

- The director of care and quality and the registered proprietor must ensure that there is a timeframe in place for the completion of policy and procedure updates.
- The director of care and quality and their management team must ensure that the outcome measurement tools identified in the policy documents are implemented in practice.
- The centre manager must ensure that they and their team undertake internal team training in the statement of purpose and function.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director of care and quality and registered proprietor must ensure that the policy and procedure document is fully reviewed and fully reflective of the relevant legislation, national guidance and national standards with regard to child protection and safeguarding.	This piece of work is currently ongoing. The subcommittee had hoped that this would have been completed by the end of March 2020 as per our original schedule, however with the onset of Covid 19 this was delayed as resources had to be ulitised in other areas. We now envisage that this piece of work will be at completion stage by the end of May 2020	A subcommittee has been formed to ensure that the policy & procedures will be regularly reviewed following finalised completion. We aim to meet every quarter as part of a review mechanism. Arrangements are in place if we need to meet sooner to update a policy with immediate effect. This also forms part of the agenda for the monthly governance meetings
	The director of care and quality must ensure that the anti-bullying policy and procedure are reviewed and updated in line with the national standards, the relevant national guidance and the child safeguarding statement.	As per comment above this is currently being reviewed in line with the policy & procedures.	As per response above. Management teams are to advise Regional Management if they require any changes to be made to the policy in line with their individual homes. This can be brought to the management meeting forum.
	The centre manager must organise for the centres booklet for young people to	The booklet for young people is currently being updated in line with the policy &	Review of the young person's booklet is to be added to the agenda for young people's

	be improved and updated to be accurate and reflective of rights based, informative and consultation based approach in line with the national standards.	procedures. It is envisaged that this will be completed by May 2020	meetings on a six-monthly basis, to include any updates young people within our service may wish to have incorporated. Regional management will also be holding listening groups with young people where this can also be discussed. Oversight will be reviewed via the monthly governance meeting.
	The director of care and quality must ensure that the restrictive practices policy and procedure is reviewed and expanded taking account of the definition and criteria provided in the national standards.	As per previous comments above this is currently being reviewed in line with the policy & procedures. We are in the process of issuing new restrictive practice logs across all homes in the organisation.	Management teams are to advise Regional Management if they require any changes to be made to the policy in line with their individual homes. This can be brought to the management meeting forum. A review of same will be conducted via the monthly governance meeting
	The centre manager and their line management must establish a system of recording, reviewing and auditing of restrictive practices.	As mentioned above we are in the process of issuing new restrictive practice logs across all homes in the organisation. From this home management will use this log to record all restrictive practices. They will also complete regular audits on same and review alongside their line management.	Restrictive practice will become a permanent agenda item for team meetings on the introduction of the new logs. Internal audits will be conducted via home management and additional auditing will be conducted via the compliance officer. These audits will be reviewed as part of the governance meetings. Furthermore,

			restrictive practices being utilised will be reviewed by the SEN group where applicable.
5	The director of care and quality and registered proprietor must ensure that there is a timeframe in place for the completion of policy and procedure updates.	This is currently underway and is scheduled for the end of May 2020.	A subcommittee has been formed to ensure that the policy & procedures will be regularly reviewed following finalised completion. We aim to meet every quarter as part of a review mechanism. Arrangements are in place if we need to meet sooner to update a policy with immediate effect. This also forms part of the agenda for the monthly governance meetings.
	The director of care and quality must update the statement of purpose and function in line with the specific criteria as identified in the national standards. The centre manager must ensure that they and their team undertake internal team training in the statement of purpose and function.	Following direction from ACIMS individual SOP&F's are being completed now for each individual home and is no longer going to be in generic form. The SOP&F is currently under review to ensure that it is centre specific. In the interim period the management team are aware of what changes are being inserted and are able to guide the team on same. Internal training on the SOP&F is	This will also be reviewed during as part of the subcommittee's role in the review of policy & procedures. Any changes will be ratified via monthly governance meetings. Regular review will be conducted via the subcommittee in charge of updating the policy and procedures. This is also discussed through the governance meetings in which the Director of Care is the Chair.

		currently being conducted in slots through team meetings. As new staff commence their induction the training co-ordinator will ensure that training on the SOP&F is a feature of induction going forward	