An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 020

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**24th ,25th & 30th of March 2021**
Registration Status:	**Registered from the 31st of March 2020 to the 31st March 2023**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**9th July 2021**

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 31st March 2008. At the time of this inspection the centre was in its fifth registration and was in year two of the cycle. The centre was registered without attached conditions from 31st March 2020 to 31st March 2023.

The centre was registered to provide care for four young people of both genders from age eleven to seventeen years on admission. The model of care was described as attachment and trauma based with the inclusion of psychology, art psychotherapy, education and an accredited experiential learning provision. It also now included the CARE framework (children and residential experiences, creating conditions for change), which was in a roll out process in 2020 and 2021. There were four young people living in the centre at the time of the inspection. A derogation to the purpose and function had been granted for one child regarding age range.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6 only
2: Effective Care and Support	2.1, 2.2, 2.3, 2.4, 2.5
3: Safe Care and Support	3.3 only
8: Use of Information	8.1, 8.2

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 3rd June 2021 and to the relevant social work departments on the 15th June 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 director of care and quality returned the report with a CAPA on the 28th June 2021. 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: 020 without attached conditions from the 31st March 2020 to the 31st March 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

The centre staff had policies in place to support their consultation practices, there were policies on children's rights, consultation, access to information and family time. The staff team had good working knowledge of the policies and the procedures in place to promote and support young people in raising their views. There were young people's meetings, a key working system and one to one work to support young people in developing their goals. Where a young person may be nonverbal there were systems in place through staffing, visuals aides and connection to schools to track the experience within the centre. Some of the young people gave feedback on being happy that they were given opportunities to bring things up either one to one or in their young people's meetings. They relayed that staff took the time to get to know them and for those there longer they told inspectors that there were staff that they would speak with or that they would contact their social worker if they needed.

There was evidence of communication with the allocated social workers who all noted generally good quality and regular communication from the centre management and the key workers. They noted the monthly progress reports as a particular source of information. There were aspects of practice decisions related to child protection reporting that a social worker and guardian ad litem found that the centre did not operate in accordance with best practice and both communicated this feedback directly to the centre and their external management. Action was initiated by the centre and organisation thereafter, a full review of this will take place when external parties have completed their investigations.

The centre did not have direct contact with all four of the families and where this was the case there were arrangements in place for the social workers to update the parents. There was evidence of this practice completed by social workers. The centre should aim to gather formal feedback from families to support the ongoing work and in particular after complaints. One parent was reported to be disturbed, when informed by the social worker, that there had been impact on their child through group living at the centre and it is important that where possible parents can have

their concerns responded to directly and that could be facilitated through social workers where needed.

Inspectors found overall that the service and this centre were child centred through its model of care but that the voice of the child must be more robustly evidenced at key junctures like significant event review groups to allow for their voice to have influence in particular with external management. For example, in the external significant events review group the voice of the child was not recorded as being influential and the organisation had not instituted end of placement feedback from young people who had moved from the centre. At the time of this inspection all four social workers were satisfied overall whilst acknowledging that there were existing group issues. The centre and the social workers acknowledged that interdisciplinary collaboration was the way to address matters and were committed to engaging in same.

There had been repetitive patterns of group impact and bullying over a number of years, actions had been put in place, were successful for periods of time but re-emerged. The complaints mechanism was utilised as one route through which incidents of these behaviours were identified. Inspectors recommended that a system of tracking be introduced to reduce the reliance on complaints being raised by young people as the springboard for addressing this.

The centre had a policy on complaints, it had been reviewed along with the full policy and procedure framework in March 2021. Inspectors found that the terminology used in practice at the centre was not mirrored in the policy, where complaints were categorised as non-notifiable and notifiable in practice on records at the centre the policy did not contain this language. The smaller aspect of the policy at the end briefly described informal complaints and lacked examples of what might fit this category. The policy does highlight the procedure for externally notified complaints.

Inspectors found that in practice non notifiable complaints procedure was routinely used and clearly documented by the centre manager who managed this process well. Non notifiable complaints were matters arising related to day to day experiences at the centres and where possible were resolved locally by staff and management. The records were clearly recorded, responded to by the manager and were known by the allocated social workers.

Complaints overall had been recorded on file and on a register of complaints with notifiable complaints, for example bullying, being reported to the social workers and relevant professionals. The majority of the complaints at the centre had been managed through the internal process with a smaller number escalated to external notification. The young people let inspectors know that they were told about the outcomes to their complaints and although not always happy with the outcomes that they knew the reasons why those decisions were made. The manager reported on complaints in a weekly operations report to the regional manager, thereafter they were forwarded to the organisations governance committee. The centre completed internal audits which were forwarded to the compliance officer, there was no specific feedback noted by inspectors related to complaints and to bullying. The audits were a quantitative process at the time of the inspection regarding noting policy and procedure compliance.

Inspectors found that in the area of complaints related to group impact and incidents of bullying that responses had been put in place but not tracked for effectiveness and reviewed as a whole. The centre management acknowledged that although young people were encouraged to complain about negative impact from peers as an exercise of their rights that more needed to be done to revitalise and enhance anti bullying work to support safe living for not only the young people but also the staff caring for them. They had already commenced one aspect of this by working with the organisations clinical team on a new approach to anti bullying work.

Compliance with Regulations	
Regulation met	**Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**None identified, one standard examined**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**None identified, one standard examined**

Actions required

- The centre must review and amend the complaints policy to contain the procedures for notifiable and non-notifiable complaints.
- The registered proprietor and the centre management must ensure that anti-bullying tools and interventions be more robust and tracked for measureable

impacts resulting in improved safety and quality of life. This work should be informed by learning taken from complaints, allegations and from young people, staff, family and professionals feedback.

- The registered proprietor must satisfy themselves that the organisation has effective mechanisms for children to provide feedback on the complaints procedure and that this is regularly reviewed.

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.1 Each child's identified needs inform their placement in the residential centre.

The centres policy on admissions was clearly stated and mapped to the organisations therapeutic model of care. The goals set out within this for a person- centred approach toward the assessed needs of each young person being referred were structured into the policy. The policy had been reviewed yearly and updated based on the services development in particular regarding its multi-disciplinary offerings such as education, occupational therapy, art therapy and psychology. Referrals were accepted from Tusla, The Child and Family Agency and from the Northern Ireland Trusts. All four of the young people were placed at this centre by Tusla and the centre accepts young people requiring support with complex emotional and behavioural needs.

The file for the most recent admission to the centre demonstrated compliance with the centres policy on admissions in that the young person met the criteria for admission and would benefit from the tailored supports inclusive of their education needs. A thorough assessment of needs had been commenced by the centre starting with a pre -placement case summary. The social work department were satisfied that this was the most suitable option for the young person at the time. A supported move to the centre was facilitated through an individualised transition plan, all plans had also to take account of Covid-19 restrictions nationally. The young person was visited in their emergency placement and provided with photos of the centre and details

about it. A visit was arranged and the move in scheduled. The young person told the inspector that although it was hard to move counties and to the countryside that the centre manager and their key worker had visited them first and gave lots of information and photos. The young person confirmed that they had a visit to the house as well, that staff had helped them settle in and that they felt much more settled now a number of months later.

The centre management completed a group impact risk assessment for the last admission, September 2020. A copy was on file and it detailed a comprehensive process involving all four social work departments. Each of the resident young people and the referred young person were considered in relation to each other's strengths and risks and a response completed with regard to how the centre and the organisation planned to manage any potential areas of risk escalation.

The inspectors found that the multiple actions identified on the plans from staffing levels to key working and implementation of the model of care by staff had been acted on by the manager and staff. The effectiveness of the range of interventions had been incrementally effective in areas for the young person themselves but had struggled to positively impact the group dynamic to the same extent. The staff all identified that the challenges at the centre related to the group and individual issues including recurring impact concerns. The staff also named that they were very committed to each of the young people having worked with them over several years.

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

The young people had care plans on file and child in care reviews had been held in line with the required timeframes, one young person had been subject to monthly child in care reviews and some absent copies of these were being followed up with the social work department involved. The centre had acted on the goals named for them on the care plans.

Each young person's file contained a placement plan, called an individual development plan/IDP, which were formally revised on a three monthly rotation. There were monthly individual progress reports which evaluated the work completed. There were monthly key working calendars and persons assigned including but not limited to the key workers. From review of records and from feedback from a young person, social workers and external professionals progress had been made relevant to the individual needs of each young person.

Each of the young people had two dedicated key workers and they worked together to discuss and identify goals from the care plan, the therapeutic needs and the young person's own wishes and aims. The centre had tools in place specifically for young people to assist them in expressing their wishes both for their placement plan and in preparation for their child in care review meetings. The young people also had access to their social workers, their guardian ad litem, family, to organisations like EPIC and to young people's meetings at the centre as additional routes to raise points important to them.

The young people had links to specialist clinical supports as recommended in line with their care plans and placement plans. The social workers were co-ordinating follow up on some dedicated areas of specialised assessment and treatment. The centre and the social workers were in ongoing contact and inspectors found that all parties were up to date and aware of the key factors impacting their young person.

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The centre was located in a rural setting within a premises and grounds that were suitable to provide safe and effective care. The layout and design of the accommodation was suitable to meet the needs of the young people although it was notable that with four young people and four staff aside from managers that the centre was very busy throughout each day. The premises were comfortable, clean, well maintained and in a good state of repair. The house was adequately heated, lit and ventilated. Bathroom facilities were adequate and afforded some privacy for each of the young people but the manager named that a bathroom would need to be retrofitted should a placement not be sourced in a suitable disability service.

The hygiene and infection control measures required and advised by public health, including a contingency plan, were in place for Covid-19. There were cleaning, cooking and safety schedules and plans in place. There were protocols and equipment in place to assist staff throughout the ongoing pandemic period.

The inspector visited the centre and all four young people were at home on that day. Three of the young people were around the main area of the house with one sitting down for an extended chat. The inspector was shown two young people's bedrooms by the young people themselves or during interaction. The centre manager showed the inspector around the rest of the property and grounds. The young person who showed their room liked it and how they had been able to personalise and decorate it.

They were near the staff office and said they preferred this as it helped them feel safer. The other young person whose room was seen had toys, visual and sensory aides in their room which was tailored to their needs, they were observed to have a staff member within close proximity at all times in accordance with their needs.

The staff and young people had adequate resources to support home education, entertainment and family contact. There were games and suitable play equipment with additional ordered and provided for without delay. The centre had some new soft furnishings and the furniture and décor was of good quality and homely. The staff sleep in the main living room due the capacity of the centre being set at four and it may be timely to review this regarding its suitability for adequate rest and privacy.

The manager provided inspectors with proof of suitable fire safety checks, the fire safety equipment, lighting, blanket and alarm system had been maintained up to date and were operational in their designated locations during this visit. There was evidence of fire drills conducted for new staff and young people moving to the centre, drills had been held both in day and night time hours, records were on file of these. Records of weekly and monthly health and safety audits at the centre were also maintained. Proof of up to date, adequate insurance against accidents or injuries was also provided to inspectors. The centres cars were subject to regular checks and managed through a fleet management system that co-ordinated safe driving feedback and services for the cars to ensure safety. The team had access to policies on safe driving in different weather conditions.

The centre had a centre specific safety statement and risk assessment developed in line with Health and Safety regulations and this was implemented at the centre. The centre manager had the lead responsibility for the health and safety matters and reported externally to the organisations maintenance department and health and safety persons. There were maintenance records at the centre and these evidenced a structured and timely response pattern to remove any risks. The centre manager retained a record of accidents and injuries to staff and it was noted that there had been 32 in 2020 and 5 to date (March 2021) in 2021. Supports had been put in place for staff through debriefing, informal and formal supervision, the therapeutic team and the organisations employee assistance programme offered to all. Training and development factors were addressed through supervision. The further reduction in the rate of accidents and injuries will rely on factors related to the additional strategies being proposed through collaborative work with social work departments, for example to increase breaks and positive contact with significant external persons

for young people. These types of interventions are in line with the centres interventions to avoid unplanned discharges.

Standard 2.4 The information necessary to support the provision of child-centred, safe and effective care is available for each child in the residential centre.

The centre had a well maintained filing system in place for all young people. The files were organised to allow for sensitive and confidential information to be suitably stored. The team had a filing template to assist them in identifying if there were any gaps in essential documents that they should follow up and request from the social work departments. The inspectors found that the files contained the core required documents such as a copy of the most up to to date care plan and if not on file it had been requested.

Whilst at the centre the inspector noted that locked filing cabinets were in place for storing the young people's files and that the managers maintained the safe storage of the confidential files. There was evidence of the manager's oversight of the centres files and in promoting good file maintenance and its importance in how it assists in co-ordinating safe and effective care for young people. All staff had completed online GDPR, general data protection regulations, training in early 2021.

Standard 2.5 Each child experiences integrated care which is coordinated effectively within and between services.

The centre had a suitable policy on discharges which contained procedures for planned and unplanned discharges. There were detailed interventions that would be implemented for planned moves but also for early intervention in a situation where a placement may be too risky for themselves and others. The centres ability to implement strategies for placement stabilisation and risk reduction had been hindered by the lock down periods during this pandemic. Such strategies were required to help build group harmony and safety at this time and the management had highlighted this to inspectors during this visit, they had ideas and options that they hoped to implement to improve the day to day living experience for all at the centre.

One young person had left the centre since the last inspection twelve months prior, this was a planned move into aftercare and all parties in the centre reported that this had been positive and managed in accordance with the young person's wishes and

their aftercare plan. The centres regional manager stated that they did not have an established system of gaining feedback from a young person after their move from the centre and hoped to initiate that as a process from now on. They do, as a company, have social events for young people who had left their care and hoped to do more in the future. An outdoor party had been held for this young person's moving day.

The centre had sourced and furnished a flat for the recent move and supported the transition which had to be adapted due to Covid-19 restrictions. There was a formal six-week post discharge support plan in place and following that informal contact takes place with the young adults.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 2.1** **Standard 2.2** **Standard 2.3** **Standard 2.4** **Standard 2.5**
Practices met the required standard in some respects only	**None identified, not all standards examined**
Practices did not meet the required standard	**None identified, not all standards examined**

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

The centre management had, following feedback from external professionals, implemented actions related to staff recognition of and response to the voice of young people during incidents in particular. The team and the young people had been through extended periods of challenging behaviours, competing needs and incidents including restraint and bullying that required particular attention.

The policy on significant events was suitable and implemented in practice with an overall well written account of what happened, however they did not always note if other children were present and there was no tracking of wider exposure of the group during incidents. This seemed to have resulted in some new information for social workers when complaints were submitted as the means of noting either direct targeting or of secondary trauma from exposure to serious incidents from others. It is important that tracking take place and a clear process put in place for recording and reporting if not meeting the threshold for a significant events report or for a child protection and welfare report being submitted. It is also important that social workers once the pandemic restrictions change resume regular visits and read records.

Inspectors reviewed the policies under which the review and learning processes for significant events was addressed and found it under two policy headings, TCI and Significant Events. The more detailed content being contained under the significant event policy. The purpose and procedures for the external SEN review group was described and they had met some but not all of their intended goals based on the inspection findings. This centre was an enhanced service provision for children and young people with complex emotional and behavioural needs so the functions of the SEN review group, the regional management and the governance team were key factors in its service provision and review. The SEN review group did not achieve its goals consistently in promoting multi agency response and planning to take action where patterns were identified. There had not been enough evidence of robust feedback to enhance and develop the team knowledge and skills in response to extended periods of challenging behaviours.

The significant events policy did not reference the team level significant events review that management referred to and the policy should be made clearer and more robust about the internal and the external significant review mechanisms.

The regional manager had started the process of analysing the structural comments on the SEN review group following feedback from the inspection process. They did so by co-ordinating with this group, the governance committee, training and clinical departments. They accepted that a revised approach was required to significantly support the team in addressing the issues identified by professionals and inspectors.

There were protective factors in place through the committed and experienced manager and deputy, the staff team were consistent and committed with a minimum of four staff per day. There was involvement by social workers and support from the clinical team, the education group and the training and development co-ordinator. The young people named that they felt happier when the young people's meetings were divided up so that they felt safer and that overall they were well cared for and had time with staff to support them and help them. The non-verbal young person was supported through visual aids and social stories.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions required

- The registered proprietor and their governance group must take action on practice approaches to the internal and external significant review mechanisms so that they are clarified, procedures updated and circulated to all. The centre management should be consulted with thereafter by the regional manager to track the effectiveness of the interventions and any further actions required.

- The SEN review group must evidence their process in responding to critical incidents and recurring negative patterns in order to track, analyse and respond to issues.
- The centre management must ensure that parents and carers are appropriately updated through the identified routes with regard to their young person's experience of care at the centre and that their feedback is taken on board.

Regulation 17: Records

Theme 8: Use of Information

Standard 8.1 – Information is used to plan, manage and deliver child-centred, safe and effective care and support.

Inspectors found that there were good quality information systems in place to support the delivery of safe and effective care, these were operational within the centre. All staff knew the structures in place to support good decision making and had confidence that their organisation was serious and proactive about making improvements. There was a genuine appreciation and record of positives, strengths and achievements by young people. At the centre there was an experienced manager and deputy manager, both worked days in support of the team of thirteen. There were handovers, fortnightly team meetings, regular supervision and oversight of the records at the centre. The organisation had increased investment in training and clinical supports, policies were reviewed and improved yearly in line with information from regulation, legislation, national guidelines and best practice. There had been investment in an enhancement of the model of care although the roll out had been hindered by the pandemic as it had been identified as a training best delivered face to face.

The centre had a risk assessment, management and reduction policy, restrictive practices, management of behaviour and placement planning policies all designed to complement each other in managing risk whilst advancing planning toward positive outcomes for young people. There had been progress for the young people there but there was risk that at the time of the inspection had been causing measureable impact on young people and staff.

Incidents were recorded, notified in a timely manner and went through a process of discussion by the team and then through external review by a dedicated team of staff

from the organisation called the significant event review team. The inspectors found that the internal and the external incident review mechanisms lacked the necessary structure and detail to track, analyse and respond to the core issues at the centre. The centre team rely on the external mechanism to prompt reflection from a fresh perspective and this was notably absent on a number of key events. The system failed to adequately track and adapt responses to complex behaviours around control issues and with regard to how staff responded to the voice of young people during and after critical incidents, in this case one involving restraint. The centre and organisations working relationships with social workers and other professionals did result in robust communications from them outlining issues and gaps, the centre and organisation then initiated correction around practices. The policy on child protection was updated with social workers noting that once identified that the centre and organisation were open and honest and demonstrated their capacity to act, review and reflect.

Inspectors found that the busy nature of the work and the need for day to day responses to pressing needs as well as the pandemic response had led to a loss of wider perspective into some long standing issues for young people. This was also identified by the centre manager and the team. It was this aspect of care that required organisational support and focused input to assist all staff, management and young people to address effectively. Inspectors found therefore that there must be better evidence of action on foot of evaluation of information generated from the centre relating to long standing issues. It was clear from review of the records of complaints, accident and injury records, questionnaires and inspection interviews that the staff team were looking for new solutions for some aspects of the work. The young people were struggling with aspects of their co-living as a group of four. This was being reported to management in supervision and in team meetings but due to the pace of work had been addressed on a case by case basis. The staff stated that they found the management supportive and proactive but all were looking for additional advice on how to move forward afresh.

There was a suitable booklet for young people that was shared with them before their move in and followed up with regard to aspects of it such as access to information during key working when living at the centre. Parents were also provided with information through the social work departments mainly and centre management should verify that leaflets had been provided to relevant parents and carers. There was a policy on access to information that outlined children's and families' rights in this regard and the arrangements in place to facilitate this access. Inspectors found that the records were well structured and securely maintained but that on the daily

logs the entries were not always in accordance with the stated policy of being free of 'value judgements, flippant remarks and colloquialisms' and should be addressed through quality improvement in record keeping. The management had recently initiated a process of promoting again to young people that daily logs were available to read with staff and it is important that the entries in the daily log keep the child's experience of this in mind.

There was evidence of regular audits internally at the centre and the manager completed a weekly operational report to their line management. The organisation had recently added to its quality assurance and compliance department and had expanded its governance committee to add an experienced external party. The effect of these recent changes were not as yet at a point of being measureable at the centre level.

Standard 8.2 – Effective arrangements are in place for information governance and records management to deliver child-centred, safe and effective care and support.

Inspectors found that there were policies in place on report writing, confidentiality and access to information, these had been reviewed in March 2021. The policy on access to information accurately referenced relevant national and EU regulations on data protection, GDPR and the national standards National Standards for Children's Residential Centres, 2018 (HIQA). There were also policies on electronic communication and governance that addressed aspects of data management in a safe and effective manner.

There was overall evidence of a system of safe and ethical information gathering to inform clinical and therapeutic planning and the majority of the records were well written and evidenced managerial oversight and comment. As stated aspects of daily logs required attention and during critical incidents team follow up on the voice of the child had been identified for attention prior to this inspection. Inspectors found that with regard to the correction and clarifying of the records relating to the identified critical incident that the manager had kept a clear and updated record on the file with all communications saved and stored appropriately. There was a further plan to address any areas identified once the outcome of the external investigation allowed for this to move forward.

The team at the centre were found to be operating in line with their electronic communication policy and utilised password protection for external communication

of confidential, sensitive information. The social workers were satisfied that they received incident reports in a timely manner, that they received the monthly progress reports and were involved in strategy and professional's meetings to co-ordinate responses. The centre management maintained a suitable register of young people in line with the relevant legislation.

The matter of return of care files was addressed under the access to information policy. The section regarding access to information in the future was referenced as being solely the role of the referring authority. In this centre for example young people have lived for five years and longer representing a significant span of their lives that this organisation could provide valuable insight into in the future. The policy should outline what information is kept with regard to lengths of stay and locations and what they may be able to assist people with in the future. All staff had completed online training on general data protection regulations, GDPR.

Compliance with Regulation	
Regulation met	**Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**Standard 8.1** **Standard 8.2**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that all parents and carers have the most up to date parent information and that this addresses access to information for same.
- The registered proprietor must ensure that there is clear evidence of action on foot of evaluation of information generated from the centre.
- The centre manager must address the quality of entries into the daily logs to ensure that they are in compliance with the policy guidelines and the model of care.

- The centre manager and the regional manager must initiate the process of gaining feedback from young people who have left their care in a structured format that can influence and confirm good practices.
- The registered proprietor and the centre manager must update the inspectorate on their proposed plan once the external investigation is completed.
- The registered proprietor must review their policies in relation to managing access in the future to any records retained by them.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1.6	The centre must review and amend the complaints policy to contain the procedures for notifiable and non-notifiable complaints.	Following receipt of the draft report the Complaints policy has been reviewed and updated to outline the procedures for notifiable and non-notifiable complaints and the policy has been updated to reflect the language now utilised. Policy to be ratified at the Governance meeting on the 24.6.2021.	Complaint's policy will be reviewed by the policy subcommittee on an annual basis or updated accordingly within an appropriate timeframe if a change is required sooner than this.
	The registered proprietor and the centre management must ensure that anti-bullying tools and interventions be more robust and tracked for measureable impacts resulting in improved safety and quality of life at the centre. This work should be informed by learning taken from complaints, allegations and from staff, family and professionals feedback.	All notifiable complaints will now be reviewed by the SERG process, where efficacy of interventions will be tracked and reviewed. Anti-bullying interventions will be informed by the outcome of the SERG. Follow up SERGs to take place within a four-week timeframe to review the interventions and efficacy of same. The Clinical team and Home Management will ensure ongoing communication via	Ongoing audits from the compliance officer will ensure that the young person's voice is captured re complaints/allegations and bullying, and this will be reported to the governance committee. Regional management will ensure that as part of their monthly visit to the home that they are able to track the quality of life for the young people in the home, by ensuring that they review any complaints for example

		the IDP process to ensure a review of bullying tools/interventions when tracking each young person's case.	and speak to the young people on same. The Clinical team in conjunction with the SEN team will track and review measures. All of this information will then inform part of quality improvement to the service and will be discussed at the governance meetings.
	The registered proprietor must satisfy themselves that the organisation has effective mechanisms for children to provide feedback on the complaints procedure and that this is regularly reviewed.	A template has been devised and is now being utilised across all homes enabling the Young People to provide a response/feedback on the outcome of a complaint. This will be reviewed by the Home Manager on a regular basis. Feedback from the young people will be shared with the team via handover and team meetings. The organisation is currently reviewing a new system which will ensure that the young person's voice is being captured throughout all systems within the organisation.	This process will be reviewed on a regular basis by Home Manager, Regional Manager and SERG, to ensure the young person voice is captured and to ensure the template is effective and fit for purpose.
3.3	The registered proprietor and their governance group must take action on practice approaches to the internal and external significant review mechanisms	A full system review is currently underway in relation to the SEN review system. The policy on SENs has been updated to reflect a flow chart showing the systems	The SEN co-ordinator will work in conjunction with the Centre manager and the Regional Manager to ensure that there is clear communication in respect of

	so that they are clarified, procedures updated and circulated to all. The centre management should be consulted with thereafter by the regional manager to track the effectiveness of the interventions and any further actions required.	for review. Regional management to alert the governance committee on SERG's which require further examination at a higher level. The working group which has been established to review the current process in place will help define this system.	reviews being conducted and clarification from the recommendation from same. All parties will work in conjunction to ensure effectiveness in tracking and/or updates required in respect of policy, which will be brought forward to the governance committee.
	The SEN review group must evidence their process in responding to critical incidents and recurring negative patterns in order to track, analyse and respond to issues.	The significant event notification policy has been updated (on the back off recent inspections) to include a flow chart system so all that staff within the organisation are clear as to the systems in place. These systems will allow for tracking, analysing, and responding to issues to ensure more effective working. We have recently employed another Social Worker (with years of experience in this field) to join this SEN team and this person will guide the SEN team through the revised systems once these are defined.	A working group has been established to review the current system with the SEN group/SERG process. From recent inspections we have noted that we are reviewing a vast quantity of SEN's and not necessarily ensuring the quality of these reviews which has impacted on the ability to foresee patterns etc. We envisage that following the overall review that we will have new systems in place by the 9.8.2021.
	The centre management must ensure that parents and carers are	Currently we have a system in place whereby Social Work departments update	A recent feedback form for parents was ratified at a governance meeting this year

	appropriately updated through the identified routes with regard to their young person's experience of care at the centre and that their feedback is taken on board.	parents/carers on the young person's experiences. We would update parents/carers directly if there was for example a hospital admission over the weekend or outside of working hours. We will review this process organisationally and link with Social Work departments to have clear parameters in place for feedback	and is now in use across the organisation. We will be asking management teams to send these biannually to parents/carers and the information received will be presented to the governance committee and will be part of the overall quality improvement plan for each home.
8	The centre manager must ensure that all parents and carers have the most up to date parent information and that this addresses access to information for same.	The parents' booklet alongside the young person's booklet is currently in the process of being updated. Once this update is complete all parents/carers will be furnished with the latest edition. We envisage this update to be completed by the 9.8.2021.	Parent's booklet to be reviewed/updated as necessary by the subcommittee for policy and procedures.
	The registered proprietor must ensure that there is better evidence of action on foot of evaluation of information generated from the centre.	With immediate effect. Regional management and centre management as part of their monthly supervision to discuss long standing issues which may still be in place and agree formulation for focus-based solutions. Reflective practice spaces have now been introduced with the teams, so this will now	Regional management to bring issues which may be long standing to the weekly Senior Management meetings for further discussion, exploration etc. to ensure that an overarching view point can be conducted by Senior Management.

		allow teams to have a further space away from their team meetings in which the team can evaluate and review in a safe space with a facilitator. Centre management will ensure going forward that the correct training is in place in a reasonable time frame for both young people and staff on issues which reoccur or are long standing.	
	The centre manager must address the quality of entries into the daily logs to ensure that they are in compliance with the policy guidelines and the model of care.	The centre manager has revisited the policy on report writing at the team meeting on the 6.4.2021 and has been consistent in addressing same at weekly handovers, to ensure consistent communication across the team. This matter is also being addressed with each individual member of the team via their supervision. The centre manager has also liaised with the training team in an effort to source recording training for the team.	Centre Management to review all recordings on a weekly basis and provide guidance and feedback to the team. Regional management to review a sample of recordings as part of their monthly visit to the home and provide feedback on same to centre management. Ongoing auditing to include quality of recording being utilised.
	The centre manager and the regional manager must initiate the process of gaining feedback from young people	Young person's feedback templates have been devised enabling the organisation to capture feedback from the young people	Feedback forms received will be furnished to the governance committee and based on information received, direction will be

	who have left their care in a structured format that can influence and confirm good practices.	who leave our care. These forms will be ratified at the governance meeting at the end of June and will be rolled out across all the homes and reviewed on a regular basis by Senior Management. We have discussed how it will be best for Social Workers to co-ordinate the completion of these feedback forms, to ensure that accurate feedback is received.	given to any changes in service that is required etc.
	The registered proprietor and the centre manager must update the inspectorate on their proposed plan once the external investigation is completed.	The external investigation has now been completed by Tusla. Any actions identified were implemented. The investigating Social Worker did visit the home to inform the young person of the outcome however the young person refused to engage. The investigating Social Worker advised that he would follow up with the young person in writing, and this is yet to happen. On receipt of this final part of the process an update will be provided to ACIMS.	The Home Manager to ensure that all allegations are reported in according with the policy on Child Protection and Safeguarding. Greater communication between Home Management teams and Social Work departments to be promoted. Ongoing communication to be held with external investigating Social Work departments to ensure that policy is being followed.
	The registered proprietor must review their policies in relation to managing	The centres policy outlines the procedures for return of children's care files to the	All requests will be overseen by the Director of Care and Quality who will

	access in the future to any records retained by them.	relevant Tusla social work departments. A record is kept of same. Any requests for records retained by the company, such as registers, are processed by the HR Department and overseen by the Director of Care and Quality.	inform the Senior Executive Team. In turn the CEO will inform the Board where applicable