An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 173

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ireland**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**1st & 2nd December 2021**
Registration Status:	**Registered with attached conditions from 1st May 2020 to 1st May 2023**
Inspection Team:	**Lisa Tobin** **Cora Kelly**
Date Report Issued:	**16th March 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 1st of May 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 1st of May 2020 to 1st of May 2023.

The centre was registered to provide therapeutic care and support to four young people aged between 10 and 14 years of both genders for a medium to long term period. There were two young people living in the centre at the time of the inspection. There was a derogation in place for one young person that fell outside of the age bracket for this centre.

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 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. This inspection was a blended inspection which included on site file review and interviews via MS Teams.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 13th January 2022. 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 2nd February 2022. Centre management and proprietors were informed on the 14th February 2022 of the decision by the Committee to propose to attach a condition to the centre's registration. The centre management or proprietors did not make any representations or appeal this decision.

The findings of this report and assessment of the submitted CAPA deem the centre not 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: 173 with attached conditions from the 1st May 2020 to 1st May 2023 pursuant to Part VIII, 1991 Child Care Act. The attached condition being that; the acting manager is required to complete the level 8 programme as stated in the corrective and preventative action plan and submit evidence of the successful completion of the programme. This condition is proposed to be attached from the 7th of March 2022 and will be reviewed on completion of course in May 2023.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

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.

There were up to date care plans on file for the two young people living in the centre however, it was noted by inspectors that one young person had care plans from January 2021 and July 2021 sent to the centre in late November 2021 prior to the inspection commencing. There was nothing to indicate that the centre escalated the delay in receiving the care plan internally or externally. There was no evidence that the deficits in care planning had been escalated to the relevant social work department. Further, the organisation did not have a procedure for the escalation of care planning matters. Inspectors saw evidence of centre minutes from the child in care review in January 2021. Placement plan goals should be guided by the care plan actions and the care plans were not on site for the young person. Inspectors highlighted that once the care plan was received, it was noted that there were very few actions identified despite ongoing concerns for the young person. Both the acting centre manager and the regional manager agreed and stated that for the next child in care review, this would be addressed to ensure all actions that are required for the young person were included in the care plan.

The other young person was under derogation and had 6 monthly LAC (Looked After Children) reviews and had monthly professional meetings with the centre management and relevant professionals including the allocated social worker and education officer, outlining where the young person was at and updates on where current goals/actions were at. Minutes were on file for the professional meetings and the most recent LAC review.

Individual placement plans (IPP's) were used as a live document. The overall document was updated over a three-month period. The most up to date IPP's were on file for both young people, however some older IPP's were not on file for one young person. Inspectors were informed some older IPP's were archived. Individual placement plans (IPPs) were in place in conjunction with therapeutic plans that linked with the work due to be undertaken with the young people. The keyworkers

had responsibility for the development of the IPP's. Individual Development Plan (IDP) meetings occurred every two months for the young people with input from the organisations clinical team for the development of the therapeutic plans. Inspectors reviewed the key working and individual work completed with the young people which were linked to the actions from the care plans/LAC review and IPPs, however it was identified by inspectors that the IPPs and key working reports required further development around better evidencing of the actual work completed. This issue had also been acknowledged by the regional manager during interview and informed inspectors that the organisation was reviewing the IPPs and looking at ways of how best to evidence the work and to have more focus on the action plans.

The young people's voices were heard through key working sessions, completion of the child in care review forms/LAC review forms and through individual young people's meetings. The young people were offered the opportunity to attend their CICRs/LAC reviews however, they usually refused. The key worker or acting centre manager advocated on behalf of young person at these reviews and feedback was given to the young person. Where family members were involved in the young person's life, their views were taken into account. During interview with one parent, they highlighted their concern with the low level of involvement they had with their child's care planning and had already spoken with the relevant social worker about this.

External supports for the young people included linking with child adolescent mental health services (CAMHS). The organisation had a clinical team that offered services to the young people including art therapy, psychology, occupational therapy and speech and language therapy. Educational assessments were identified in the care plans for the young people and were outstanding actions. Social work departments and centre management were in the process of following up with the educational assessments.

Inspectors noted both young people's educational needs were an issue identified in their IPP. One young person was receiving one hour per day of education from a teacher within the organisation and was awaiting a placement in a school that could offer the required supports needed. The other young person was currently enrolled in school and refused to attend. Aspects of independent living skills were addressed with the young person in the centre but there was no evidence of core subjects in education being addressed for the junior cycle. Inspectors noted that an incentive-based approach had worked in October for attendance in education, however this approach hadn't been used again. Inspectors were informed of contact with the

relevant school however, inspectors saw no contact with the education welfare officer. The young people must be supported in their education with all resources explored to ensure they receive adequate education for their age and development.

Inspectors reviewed records of contact with social workers which was frequent by phone and email. There was also evidence of on-site visits to meet with the young people. Social workers informed inspectors during interview that contact was effective and that there was a strong working relationship and common goal to achieve what was in the best interests of the young people.

Compliance with Regulation	
Regulation met	**Regulation 5**
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 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The acting centre manager must ensure that up to date care plans are requested for young people and are on file to guide the actions required in the IPPs.
- The acting centre manager must review the IPPs and key working documents ensuring the work undertaken was being evidenced appropriately.
- The acting centre manager must ensure that IPP's are addressing the deficit in education for the young people and ensure that they are supported with all resources explored to ensure they receive adequate education for their age and development.

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.

Leadership was demonstrated by the acting centre manager, deputy manager and the regional manager with oversight of the young people's records, leading team meetings and addressing risks in the centre. There were clearly defined governance arrangements and structures in place. The staff team were aware of specific roles and responsibilities of all staff when asked during interview, however the role of mandated person and the reporting of a child protection and welfare report required review to ensure staff were compliant with the centre's child protection and safeguarding policies and Children's First: National Guidance for the protection and Welfare of Children, 2017. The acting centre manager must ensure that the staff team understand and were aware of their responsibilities when reporting child protection concerns.

Inspectors reviewed audits completed by the acting centre manager, regional manager and the compliance officer. The acting centre manager completed a themed audit against the National Standards for Children's Residential Centres, 2018 (HIQA) and completed file audits for the young people. Inspectors noted deficits in both audits that had not been captured by the acting centre manager. The acting centre manager had not received feedback on the themed audit completed. Inspectors were informed that the organisation were reviewing audits and training was part of the action plan moving forward. The regional manager completed operational reports/audits on the centre with action plans attached. A quality assurance audit was undertaken in February 2021 against themes 2, 6, 8 & parts of theme 3, again with actions identified. Inspectors noted that there was a delay with the audit process as the action plan was not received until July 2021 after having the audit completed five months previous. A review of the CAPA from the previous inspection in October 2020 was also part of this audit. The auditing system required review to ensure that audits and action plans were completed in a timely manner. New staff in management posts require support and training in order to undertake the audits

effectively, as identified by the current acting manager in order to complete the audits accurately.

There was a service level agreement in place that was signed with Tusla's funding body in July 2021 for the next two years. Six monthly reports were required from the organisation to show compliance with relevant legislation and national standards.

The acting centre manager was the person in charge who had overall accountability and responsibility for the delivery of service. Policies and procedures were in place and were reviewed regularly with the organisation's policy review group. They were last reviewed in August 2021 and inspectors were informed that there were a number of policies currently under review relating to auditing, risk management and identification of the escalation process within the organisation. The organisation's policy on leaving care was reviewed by inspectors due to a young person leaving the service two weeks before inspection. The policy required review regarding the involvement of the organisation with young people that leave the centre as inspectors found what was actually occurring was not following the centres own policy.

Inspectors found the centre had a risk management framework in place which included pre-admission risk assessments, individual risk assessments, individual crisis management plans and absent management plans. During interview, the regional manager informed inspectors that a risk matrix was being introduced which would help identify risks that require escalation both internally and externally. There were procedures and safety plans in place for the young people when needed which were reviewed regularly by management and the team at handovers, team meetings and during supervisions.

The internal management structure had a new acting centre manager and a new deputy manager. There was only one staff member identified as a senior practitioner and was currently in training. There was new staff in the centre that would further benefit from senior experienced staff on the team which would help with an appropriate management structure within the centre.

There was a deputy centre manager in place who stepped up when the acting centre manager was absent. Inspectors saw evidence of written delegation of tasks for the deputy and for other staff members who had identified roles and responsibilities within the centre.

Compliance with Regulation

Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider and acting centre manager must ensure that Children's First Guidelines 2017 and centre policies regarding reporting a child protection welfare report form are implemented when required.
- The registered provider must ensure that a robust review of the auditing system is undertaken, and supports/training given to managers in undertaking the audits in place.
- The director of services must review the policy and procedures around leaving care and ensure that the supports outlined in the policy are followed through with the young people.

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.

Externally within the organisation, workplace planning meetings were newly introduced and occurred weekly and staffing levels/needs were discussed at senior management meetings. Inspectors reviewed the roster and saw that there were two sleepover staff and one day shift staff per day, however, one young person was funded for 2:1 staffing due to the challenging behaviours of that young person. However, these staffing levels were not always maintained in practice as incidents were noted by inspectors after reviewing relevant paperwork and saw that two incidents had

occurred in November 2021 when only two staff were on duty which involved the need for physical intervention during one of these incidents.

Rosters over a three-month period were reviewed, and inspectors saw that staff were supporting other houses within the organisation, in particular in October 2021 which left deficits and staff shortages in the centre when there was a requirement of four staff per day due to there being three residents in the centre at that time. Inspectors were informed staff were required in another house due to a prolonged discharge, a covid outbreak and to assist with staff requiring isolation.

A selection of personnel files was reviewed and require further oversight as verification of qualifications and references were incomplete. Some deficits were also noted in core training required for the model of care, first aid and fire safety on site training.

Currently there were sufficient numbers of staff employed in line with the statement of purpose, which included an acting centre manager, a deputy manager, one senior practitioner in training and twelve social care workers. The staff team had a social care degree or equivalent. It was identified in interview that the acting centre manager did not have the relevant level of qualification or experience required as per memo from Alternative Care Inspection Monitoring Service dated February 2020. The regional manager was asked about the decision to place a person not appropriately qualified or experienced in the role of acting manager and inspectors were informed that it was felt that with extra support, supervision and guidance from senior management, this would be sufficient.

There was a staff retention policy brought in place after the last inspection, which identified the importance of a stable team in the centre. Inspectors were informed the staff retention policy was being reviewed following another inspection within the organisation. The acting manager was the third manager since the last inspection. Seven staff had left the centre since the last inspection for opportunities in other agencies, promotions within the organisation, further education and also due to the distance of commute to work. The young people had spoken to their social workers questioning why staff leave them. Exit interviews were undertaken and staffing was regularly discussed at senior meetings and team meetings. There was no relief or bank staff identified on the staff information form. Inspectors were informed in interview that there was one staff on the relief panel for the centre, but had not been utilised as the core staff filled the rostered hours which included covering annual leave, however as noted above, staff shortages were noted on rosters. A review of the

relief panel system was required. There were incentives in place to retain staff which included supervision, a working group, listening group, counselling, pay increases and increments. New incentives added included sick leave pay and maternity pay. These were introduced after being identified as issues in exit interviews and feedback from the listening group. Social workers identified that the changes in staffing had been noticed and one spoke of the impact on one young people.

There was a formalised on-call procedure in place for each region for evenings and weekends which was deemed effective by the staff during interview.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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 and director of quality and care must ensure that a robust review of the workforce planning is undertaken to ensure the appropriate number of staff are on shift supporting the needs of the young people and abiding to agreed funding staffing for the young people.
- The registered provider and director of care must ensure that appropriately qualified and experienced staff are employed as per memo from ACIMS.
- The director of care and acting centre manager must ensure the recruitment and training process is robust and in line with centre policy.
- The director of care must ensure there are regular relief staff identified and available to support the team and to look at an organisational review of the relief panel system.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager must ensure that up to date care plans are requested for young people and are on file to guide the actions required in the IPPs.	Future delays in receiving care plans will be raised with the social workers/department within an appropriate and specified timeframe.	Establishment of an escalation policy will inform procedure for pursuing outstanding care plans and ensure that there are not time delays in following up with same. The policy review group are in the process of creating the escalation policy and the management team will follow this policy in house.
	The centre manager must review the IPPs and key working documents ensuring the work undertaken was being evidenced appropriately.	New template for Individual Placement Plans (IPPs) has been developed and will be operational in February 2022. The management team will be responsible to review all IPP's and ensure they are in line with the care plan and that keywork sessions are satisfactory and relevant to each individual young person.	Clearly defined action plans are now incorporated in the new Individual Placement Planning suite of documents. These will be overseen by the management team alongside the keyworker monthly. The multidisciplinary team will also have oversight bimonthly at IDP meetings.
	The centre manager must ensure that IPP's are addressing the deficit in	Both young people have returned to education placement on a full-time basis.	Education is a permanent agenda item on each young person's IPP, which provides a

	education for the young people and ensure that they are supported with all resources explored to ensure they receive adequate education for their age and development.	Incentives are being used to encourage continued attendance and engagement. Regular contact with both young people's school placements is ongoing to promote support for the young people.	forum for any issues pertaining to education to be discussed within the multidisciplinary team and goals and action plans to be developed. This is overseen by the keyworker and the management team.
5	The registered provider and centre manager must ensure that Children's First Guidelines 2017 and centre policies regarding reporting a child protection welfare report form are implemented when required. The registered provider must ensure that a robust review of the auditing system is undertaken, and	With immediate effect - Children's First Guidelines 2017 was discussed formally with all staff members via the supervision process in January 2022. All staff members directed to review and revise these guidelines. The management structure will also be reviewed to meet the demands of the organisation given its current size and	All staff are obliged to successfully complete Children's First E-Learning programme as part of their induction programme and a full day Children's First training during their probationary period. This is conducted and oversee by the training department. The management team must ensure all mandatory training is completed by staff members. A training schedule is devised by the training department. It is the responsibility of the management team to schedule training in line with the rota. An audit is completed by the training department and by home management. A new software system in place will ensure there is a robust auditing system in place across the organisation. The system is

	supports/training given to managers in undertaking the audits in place.	future development. All areas for oversight and service improvement will be raised to the Governance Committee for implementation of same. Guidance framework delivered by compliance officer to support managers in providing a clearer understanding of the auditing system. Leadership developmental group established to assist and support new managers within their role which includes audits. Regional manager oversees audits during monthly home visits.	currently being implemented and training has begun for managers and staff. The system will be operational in spring 2022. In conjunction with this the establishment of the leadership developmental group will offer support to managers starting the role.
	The director of services must review the policy and procedures around leaving care and ensure that the supports outlined in the policy are followed through with the young people.	The Director of Care & Quality will formally review same alongside the Regional Management team on the 7.2.2022	Ongoing review of the policy and procedures is conducted by the policy & procedures subcommittee. Regional management alongside home management will ensure that there are clear and defined supports and timescales in place prior to a young person leaving care, and this will be agreed formally at a young person's review.
6	The registered provider and director of care must ensure that a robust review of	Full staff complement at present which consists of consistent team and qualified	Actions from workforce planning meetings discussed with all managers during

	the workforce planning is undertaken to ensure the appropriate number of staff are on shift supporting the needs of the young people and abiding to agreed funding staffing for the young people.	personnel in line with the memo from February 2020. Workforce planning meetings continue to take place, where the Director of Care & Quality, Regional management team and HR discuss staffing levels, recruitment, and retention. Strategies were discussed and devised to resolve and or manage any staffing deficits. House rota was altered to ensure the appropriate number of staffing levels were in place.	management support meetings. Staffing levels discussed by management team and staff team in relation to group dynamic. Shift patterns altered to ensure adequate staffing levels. The management team are responsible in ensuring this is implemented on the monthly rota and adhered to.
	The registered provider and director of care must ensure that appropriately qualified and experienced staff are employed as per memo from ACIMS.	All staff working in the home are appropriately qualified as per memo. In relation to the position of the Acting Home Manager, permission was sought and granted from R & I for her to undertake this post. Ashdale Care are fully committed in supporting the current Acting Home Manager in obtaining her Level 8 qualification. This course will commence in September 2022.	Acting home manager currently completing paperwork in relation to level 8 qualification. When paperwork is fully completed and enrolment verified, evidence will be forwarded to R & I.
	The director of care and acting centre	Staff recruitment and training will	A new system has been implemented

	manager must ensure the recruitment and training process is robust and in line with centre policy.	continue to be informed by policy. All practical training components will be completed once the current covid restrictions allow for this. Fire practical training scheduled for Feb 2022.	whereby the training team will send out a monthly audit of training needs analysis to home managers.
	The director of care must ensure there are regular relief staff identified and available to support the team and to look at an organisational review of the relief panel system.	There is one identified bank staff member allocated to the home who is available to complete shifts as and when required. A bank list has been devised and offered to all homes to utilise when required.	Bank staff are regularly recruited and allocated across the organisation. The organisation now has a dedicated recruitment officer in place. Regular reviews of the relief panel are conducted by the HR team.