An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 056

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**01st 02nd & 06th December 2021**
Registration Status:	**Registered from the 14th of January 2021 to the 14th of January 2024**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**24th February 2022**

Contents

1. Information about the inspection **4**

1.1 Centre Description
1.2 Methodology

2. Findings with regard to registration matters **8**

3. Inspection Findings **9**

3.1 Theme 2: Effective Care and Support: Standard 2.2
3.2 Theme 3: Safe Care and Support: Standard 3.2
3.5 Theme 5: Leadership, Governance and Management: Standard 5.2
3.6 Theme 6: Responsive Workforce: Standard 6.1

4. Corrective and Preventative Actions **22**

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 14th of January 2015. At the time of this inspection the centre was in its third registration and was in year one of the cycle. The centre was registered without attached conditions from the 14th of January 2021 to the 14th of January 2024.

The centre was registered to provide specialist care and accommodation on a medium to long term basis on a multiple occupancy basis for up to four young people of both genders from eleven to seventeen years on admission. The staff team worked through a therapeutic practice model which was trauma and attachment informed. There were four young people living in the centre at the time of the inspection. One young person had been placed there under a derogation process overseen by the Tusla alternative care inspection and monitoring service, ACIMS, and this was a child significantly below the age of eleven.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make. During this inspection the frame work was expanded to include Theme 3, standard 3.2 based on information arising.

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 4th of January 2022 and to the relevant social work departments on the 4th of 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 director of care and quality returned the report with a CAPA on the 27th of January 2022, after an extension to its original return date of the 18th of January was agreed. This was deemed to be satisfactory and the inspection service received some evidence of the issues addressed at centre level and through the provision of dates of completion for the actions agreed at external management level.

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: 056 without attached conditions from the 14th of January 2021 to the 14th of January 2024 pursuant to Part VIII, 1991 Child Care Act.

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 current care plans on file for all four young people at the time of this inspection, one was just coming out of date as the November care plan had not yet been provided for the file. Monthly child in care reviews were occurring for young people aged twelve and under, but in some circumstances the care plans created following these reviews had not provided to the centre. One of these young people no longer had an allocated social worker and the social work team leader had recently gone on planned leave resulting in uncertainty about who would complete the monthly reviews due next.

An older young person was also no longer assigned a social worker or a social work team leader as both young people were from the same area and shared the same social work team. The principal social worker had been in communication with the centre and the outgoing social work team leader had outlined some short-term procedures for the gap. Inspectors were waiting to speak with the principal social worker for this area at the time of the draft report and had not spoken to the PSW by the time of the final report. There were errors on the 2021 care plans on file for one of these two young people, their age and school were incorrect on two care plans and items for completion by the social work department were outstanding at the time of the inspection (for example, the provision of an accurate immunisation history). The centre manager had written to the principal social worker holding oversight of the cases to request the November care plan, social work allocation updates and missing care plans from earlier in 2021.

There was evidence for many of the statutory reviews for young people that family members and teachers attended. The service's clinical team members did not attend reviews and this may be useful for example where they have completed specific interventions or assessments or where a placement may be at risk of breaking down.

Each young person had an individual development plan, IDP, which was the placement plan and the therapeutic plan combined, these were on file for all young

people. These were developed on three monthly cycles and were informed by the care plan actions through rolling monthly review and update. Staff noted that they would like to have closer participation between the clinical and residential team as presently much of the communication was in writing where it came to reviewing and updating the placement and therapeutic plans.

The centre manager and the regional manager named that review of the placement plan format was underway and inspectors agreed that our findings supported the need to do so. Whilst it was a strong format some of the plans were large and repetitive throughout the year in particular for the young people living there a number of years. They did not align well with the key working and case management tools and calendars with identification of individual goals, progression and outcomes hard to track. There was evidence of positive staff practices and progress for the young people in relation to the areas of their life like school, health, life skills, family and provision of therapeutic sessions. There was evidence of key working and of opportunity led work. Staff were assigned to pieces of work based on relationships, skills or if otherwise best placed to do certain work, they did so alongside the key workers who managed the whole case and file.

The centre had a policy on placement planning, within this policy there were references to a young person's placement plan consultation process called 'Map' which was not in fact in use at the centre. A number of consultation tools had been utilised in recent years, but all had lapsed and had not been replaced as yet. Therefore, the involvement of young people taking account of their age and stage of development was difficult to verify although two of the young people told inspectors in their questionnaires and in person that they worked with their key worker on their placement plan, a third much younger child told inspectors that they had a key worker who helped them. The centre manager and the regional manager stated that they were aware that additional tools and options were required to meet their goals on consultation with young people and with families regarding plans at the centre.

There was evidence of the staff communicating directly with some parents based on the court and social work guidance and direction. One set of parents did not reside in this country and they were communicating occasionally through the social work department who were trying to establish more contact. The family members for the young people had when possible been invited to visit the centre but the main focus was bringing young people to access in their home areas.

The young people all had access to occupational therapy, art therapy and a psychologist for one to one work or assessment. All four of the young people had utilised different suitable clinical and therapeutic services and continued to do so as needed. The social workers and the clinical team with the centre agreed on assessments needed and external counselling was offered as an option for a young person to ensure that they an option outside the service.

There was evidence on file of communication with all of the social work departments. There was evidence of staff listening to young people and advocating for them to their social work departments, for example regarding family access. Social workers told inspectors that the quality of communication from the team and in particular the centre manager was of a good standard and clearly focused on the best interests of each young person.

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 centre manager must ensure that there are mechanisms for consultation with children and young people taking into account their age and developmental stage.
- The centre manager and regional manager must ensure that the revised placement planning and key working formats are rolled out within a structured timeframe.

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

Inspectors were undertaking a structured inspection protocol but expanded the focus of the inspection to include Theme 3: Standard 3.2 to examine the circumstances surrounding some matters arising. Inspectors found on the records at the centre that they had been addressing issues related to negative group dynamics for all of 2021 and that these had escalated to reports of bullying on multiple occasions. Inspectors were also informed by a young person in writing and in person that they were being bullied and felt unsafe at the centre.

There were policies on 'supporting behaviour change', on 'management of challenging behaviour' and on 'consequences'. The model of care was reflected in the policies and the tools for planning named within these policies were implemented within practice. The staff team were trained in the model of care and in the model of management of crisis behaviour like violence and aggression. The team had access to the clinical team for advice and up to date knowledge in the relevant areas of trauma informed care. There was a good understanding of the trauma and attachment origins or drivers for behaviours. There was evidence of positive regard for each individual child and young person from the staff team. Inspectors found though that the net result was not a real and sustained decrease in harmful behaviours towards each other amongst the group of children and young people who ranged in age from nine to seventeen. There was evidence of staff holding accountability with the older peers, naming and encouraging positive engagement and disengagement from conflict cycles and practicing options and scenarios with them. The younger peers were maintained in tight schedules daily in order to minimise overlap. There were life space interviews completed, safety and risk plans and crisis support plans. There were significant event review and case reviews conducted internally.

There was also a policy on anti-bullying but this policy was not updated to reflect procedural changes the service committed to earlier in 2021 in response to another inspection. It did not address how the wider service will support a centre and its young people when first line interventions and positive behaviour support prove ineffective.

The centre manager and the team had rightly identified, from the beginning of 2021, that the group impact referred to as 'group disorder' and the multiple reported incidents of bullying and assault were an issue of serious concern. The team implemented the range of responses open to them and the centre manager escalated the matter through their risk register, to the regional manager in the operational reports and to the governance committee on two occasions in 2021 as a 'Red', that being the highest category, of concern or risk.

The social work departments for all four young people had been informed about the issues arising and the current situation for their young person. Where a Guardian ad litem (GAL) was assigned they were also informed, one GAL confirmed this. There had not been a combined strategy meeting involving all the social work departments and GALs, this was now complicated by the absence of a social worker and a social work team leader for two of the young people. A GAL had written to the principal social worker for the area involved who stated that recruitment was at an advanced stage to fill the social worker post.

Inspectors had been told earlier in 2021 by the service that in response to making group dysregulation and anti-bullying responses more robust that there would be a clear system from the centre level to governance committee level of responses and of tracking and review of efficacy of interventions regarding bullying. It was also stated that this would be underpinned by external audit, external SERG follow up and by the regional manager role. There was evidence of the regional manager responding, reviewing, meeting young people and staff. They acted as a bridge to the clinical team and the training team to seek additional advice and support to address the recurring issues. They attended the critical incident expert significant event review group. They described the measures as protective in order to prevent placement breakdown because, they stated, that all four young people loved their placement at the centre. It had also been committed to that the expert group SERG once it reviewed incidents regarding bullying and assault would formally review these at three months with a quality improvement plan being generated to support tracking and outcomes. Inspectors found that whilst parts of the promised processes had been implemented that external audit, the three month formal review by the external SERG and the quality improvement plan were not in place.

Inspectors found that the centre manager and the team had responded clearly and transparently to the events as they arose, all were reported and the rights of all four young people to safety were weighed equally. The centre manager organised the

staffing well in response to the individual needs but this also required additional staffing funded on a temporary basis by one social work department in order to minimise opportunities for young peoples clashes to either occur or to escalate. This had reduced regularity but not the intensity when they occurred. The main effective tool throughout the year had been separating of the group of four, in particular going for drives for the older peers. The centre manager and the team had also advocated strongly and effectively for increased access and time away from the centre for the young people and this was positive factor in their lives.

Overall Inspectors found that more effective and concerted action must be supported for implementation at the centre to address the level of group impact and allow for a safer day to day shared life at the centre for all young people as planned for and devised by the team.

The centre had a policy on restrictive practices and there was a record of any restrictive practices in place, these were typically standard house safety based restrictions on sharp knives or chemical cleaning materials.

Compliance with Regulation	
Regulation met /not met	**Regulation 16 - Not assessed**

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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The director of care and quality must ensure that the policy on anti bullying and the escalation framework identified previously in 2021 is acted upon fully without delay.
- The director of care and quality must ensure that external audit takes place with a clear system, from the centre level to governance committee level, of responses and of tracking and review of efficacy of interventions regarding bullying.

- The social work departments and the centre management must ensure that the planned multi disciplinary meeting takes place as soon as is practicably possible.

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.

The manager of the centre had worked at that centre for over six years in various roles and has now been the centre manager for two and a half years. There was positive feedback on the leadership provided at the centre from social workers, other professionals and staff. The young people named them as someone they could talk to if they needed assistance. The centre manager was committed, knowledgeable and attentive to the goal of good quality long term care for the four young people. They were open and accountable about the group dynamics and their impact on the centre. The centre manager had oversight of the team's day to day work, attended team meetings, completed supervision and provided leadership on actions in response to needs at the centre. They also completed monthly internal thematic audits structured in line with the national standards. These were sent to the regional manager and to the compliance officer and the centre manager generated and managed their own actions and action plans. There had been no quality assurance of the audits generated by the centre manager nor external audit of the centre in 2021, one was scheduled for the weeks after this inspection visit. The structure for the audits had not been reviewed to determine if it met the organisation's overall governance goal of having systems to identify, value and promote good practice.

There were fortnightly team meetings, monthly IDP meetings and daily handovers. There were records maintained of delegated tasks that were assigned to staff and these were tracked by the centre manager.

Typically, the centre manager had a deputy manager in post, the long term deputy left their job in September 2021 for a social work post and the post had been recruited for, with the identified person starting in January 2022. The centre had a social care leader level post called a senior practitioner, there was one such post

allocated for this centre. This post was filled at the time of the inspection and the centre manager was supported by the senior practitioner and an experienced staff from another centre with management tasks two days per week whilst the deputy manager post was vacant. Since September the centre manager's leave was covered by the regional manager typically the deputy manager acts up for periods of leave. The centre manager maintained structures and systems in place during this period but named that it was a large work load and required the posts to be filled in order to meet all management tasks over time.

There were monthly managers' meetings held and there was evidence in these records of discussion on staff learning and ongoing upskilling in the national standards and the policies derived from them. Inspectors confirmed that all staff had access to the policies through the service's online systems and a hard copy was maintained in the office. The policies were updated by the service's policy group and circulated thereafter. The last policy review was completed in August of 2021 and staff were alerted by email, they were discussed at handovers and team meetings, for example the safeguarding policy and lone working policies had been updated. Additional policy work was required, and some was ongoing at the time of this inspection, for example the risk management framework was under review.

The organisational structure of the service included a regional manager whose role it was to oversee the work at the centre. They completed this through monthly visits, receiving weekly reports and sitting on the senior management team meetings, SMT, and on the service's critical incident significant event review group, SERG. Whilst aspects of this structure worked well it was compromised by the pandemic and by a disruption to the services intended auditing structure during 2021. The external quality assurance and auditing system had not been in operation effectively and the regional manager acknowledged this. They named that the service had now engaged with an external consultant to revise key areas of documents and systems in order to strengthen the overall systems, including the tools for oversight at the regional manager level.

The wider structure of the company was outlined on an organisational map and in a governance framework statement. The centre signed a new contract with Tusla, the Child and Family Agency for the provision of service, the agreement was completed in August of 2021.

The measurement of risk was done through a colour coded matrix with how the risk levels were determined and the actions thereafter not being fully defined. Inspectors

were informed that a new risk matrix and risk management framework was being devised and training being organised for 2022. Inspectors found that the policy in place did not identify the process of risk escalation internally nor did it represent external risk escalation to Tusla in a clear manner. A strengthening of the working framework was required in order to create a good working policy for staff who, inspectors found, had a good core awareness of the principles of identification, assessment and management of risk.

The centre manager had a risk register in place that had been reviewed quarterly in 2021. This was structured around four measurement categories from low to extreme, the procedures for each category were briefly outlined, for example extreme would be under daily review at the centre and weekly by the service's senior management team, SMT, there were no extreme rated risks on the register at the time of the inspection. There was evidence of the regional manager review of the register and of review at the monthly managers meetings. There was no corroborating single record of SMT or governance committee review of higher rated risks that persisted. The centres ongoing group impact was recorded on the register and rated high. The staff team were familiar with the risks and were clear regarding the centre-based work that they were to undertake and the tools in place to do so. They completed individual crisis support plans, absence management plans, supported the centre manager with the review of the risk management plans and completed the key work identified to try to achieve risk reduction. They completed internal significant event reviews with the centre management at team meetings.

Each young person had a risk management plan and these were reviewed monthly or as the need arose. Risks were identified from significant events, episodes of missing and other new or historical areas impacting that young person's life in a manner likely to be detrimental to their safety and/or others. Each area had a high, medium or low categorisation within the plan, the preventative and immediate response measures listed. The area of risk that these plans didn't manage to decrease was negative group impact and episodes of bullying that occurred with that. The manager was escalating these risks but the external co-ordinated response was difficult to track and lacked a cohesive framework.

A preadmission collective risk assessment had been completed for each young person and a social worker stated that all the social workers communicated preadmission when their young person was moving to the centre. Inspectors found in the preadmission risk assessment information that the two young people who had overlapping risk areas have struggled significantly throughout the shared placement.

At the time of the admission, one was resident in the centre, the other was being moved from another centre within the company due to behaviour management issues. In this instance the actions became reactive as opposed to preventative once the placement commenced. The current solution at the time of the inspection was that one young person would move to another centre within the company. Inspectors were assured by the social worker, the centre manager and the regional manager that although this was the solution identified but that the young person could say no and that this would be respected, for example the young person had turned down one centre and now was looking at a move to another centre within the company after Christmas.

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 director of care and quality must ensure that effective processes and resources for external auditing including of the centre's approach for managing behaviour that challenges, as required by the National Standards for Children's Residential Centres, 2018 (HIQA) are put in place.
- The registered proprietor and the director of quality and care must ensure that the intended governance framework of service improvement and shared learning is fully realised and that responses to high level escalations from the centre level are clearly documented from the governance committee level.
- The director of care and quality must ensure that the policies and procedures are updated without delay to include essential improvements in policy including procedures for anti-bullying responses, risk management and escalation procedures.

- The centre manager and the regional manager must ensure that the level of risks identified from pre-admission risk assessment processes are fully taken account of when determining thresholds for admissions. Learning from previous admissions procedures must be included in a centre quality improvement plan for 2022.

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.

The centre manager completed a weekly HR report as part of the system of workforce planning that started at centre level. The weekly reports were collated by the HR department and the regional manager who met on a monthly basis to discuss and action any items. The regional manager stated that these meetings will move to weekly due to ongoing service requirements in recruitment. The centre manager and the regional manager tracked these actions through their own weekly operational report, their supervision and the regional managers monthly onsite visits to the centre. The service had recruitment procedures ongoing for the whole organisation and from these persons were matched to the centre's needs. At the time of this inspection there were two posts to be filled. The deputy manager post, which had been vacant since September 2021, had been recruited for and that person was due to take up the post in January 2022 and one social care worker post was also to be filled. The centre manager and the regional manager sat on interview panels as part of their roles. Inspectors reviewed two sample personnel files and found that they were in substantial compliance with vetting requirements, one personnel file required both a copy of and verification of a qualification.

The staff training status and staff feedback was discussed at managers meetings and in the operational reports from the centre manager to the regional manager. The centre manager had clearly outlined any risks or deficits in training and staff capacity and plans were in place to enhance internal training within the service. Inspectors were informed that during 2021 that the internal training service called TAP had reduced in availability. Training in core requirements like the model of care, the

behaviour management certified training, first aid and fire safety had been prioritised.

The staff team comprised of eleven staff outside of the manager and deputy manager, seven worked 169 and four others worked a base line of 120 hours up to 160 per month. Fifty percent of the staff team were qualified in social care. There were two dedicated relief staff and a third relief staff was joining at the time of the inspection. There was an additional staff member who was not qualified in social care and undertook a house parent style role. They worked outside the general roster providing homely living support. The manager stated that there had been a period recently with college assignments, study leave and pandemic impact that required them to complete some shifts. On occasion due to additional staffing agreed with a social work department for one young person a staff from another centre was utilised and that this was typically one consistent person. The roster evidenced that a minimum of three staff worked on shift with management support Monday to Friday. The additional staff allocated to a young person was utilised for weekends, holiday periods and other key junctures for that young person, this was agreed with the social workers involved. This allocation was under review. It was transparently recorded on the HR reports that since September there have been junctures where the centre manager had struggled to fill the roster and completed shifts themselves to ensure familiarity and continuity for the young people but also due to difficulties within the wider service in recruitment and retention of staff. This centre had maintained their core group of staff in the main and this was a protective factor in their provision of care.

A number of staff retention measures have been introduced, these included improved pay and conditions, reduction in hours for staff who apply for same for family and other reasons, sick and maternity pay had also changed. There were staff care systems in place and options for further support through the clinical team and through the formal employee assistance programme. The staff were familiar with the options in place and those spoken with named that they were settled and happy in their posts within this centre.

There was an on call policy and procedure in place with a recording system. The on call was shared between five centres a region. An on call document was formulated every Friday and handed over to the relevant centre manager on the Monday morning. There was senior on call for emergencies and critical incidents. A staff member undertaking on call responsibilities described an induction to this through their manager and the shadow support provided to them in transitioning into this

task. Records of the on call service reviewed by inspectors confirmed that the structure as described was implemented in practice.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

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

Actions required

None identified

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 there are mechanisms for consultation with children and young people taking into account their age and developmental stage.	With immediate effect – The Young Persons voice has been added to Individual Placement Plans to ensure consultation with the young person prior to IPP meetings and this is recorded with immediate effect. Young People will be provided with an IPP/Team Meeting feedback form by their keyworker, so they are aware of content covered and decisions made in meetings with immediate effect. MAP Meetings have been reintroduced and young people's Child in Care Review forms and Feedback forms are already implemented.	The home manager will have oversight of Individual placement plans and feedback forms to ensure compliance. As part of the regional managers key task list on their visit to the home monthly, they will have governance on the consultation that is occurring for the young people.
	The centre manager and regional manager must ensure that the revised placement planning and key working	The organisation is currently undertaking a complete overview of the placement planning process to ensure there is clear	The home manager will ensure placement planning will be a permanent item on team meeting agenda and there is a clear

	formats are rolled out within a structured timeframe.	guidance on accountability and responsibility on goal setting with key working formats and review. A new recording template has now been devised which will be ratified at the governance meeting on the 27.1.2022, so it can be implemented across the organisation from February 2022.	recording of all development and review of placement plans on file. Checks will also be conducted as part of a regional manager's home visit to ensure that placement planning is reviewed appropriately.
3	The director of care and quality must ensure that the policy on anti bullying and the escalation framework identified previously in 2021 is acted upon fully without delay.	The policy on anti-bullying has been updated to include an escalation framework which is to be used alongside the organisational wide escalation policy. The escalation policy the anti-bullying framework is with the governance committee for ratification and will be rolled out to all teams following the management support meeting on the 17.2.2022.	Escalation policy will be rolled out to management teams in February 2022, which will have identified trigger points and preventative strategies. Regional management via their management support meetings, which continue to encourage management teams to ensure compliance with escalation frameworks. Our SEN team will add an extra layer of governance as part of their recommendations vis SERG's on noticing emerging/continuous patterns of behaviour.
	The director of care and quality must ensure that external audit takes place	The organisation is reviewing the auditing process and will be introducing the	The new auditing system software in conjunction with the recruitment of a

	with a clear system, from the centre level to governance committee level, of responses and of tracking and review of efficacy of interventions regarding bullying.	auditing system software early in 2022. The management structure will also be reviewed to meet the demands of the organisation given its current size and future development. All areas for oversight and service improvement will be raised to the Governance Committee for implementation of same. This new system once digitalised will allow for effective tracking and review by not only home management, but regional management and the SEN team, and will allow for trends such as bullying to be identified more quickly and more effective responses to interventions regarding same.	second Compliance Officer will ensure there is a robust auditing system in place across the organisation. The auditing system software is currently being implemented and will be operational in 8 – 10 weeks. The auditing position is currently being advertised and we hope to have this post in operation by the 1.4.2022
	The social work departments and the centre management must ensure that the planned multi disciplinary meeting takes place as soon as is practicably possible.	Home Management will contact all social work departments and request a multi-disciplinary meeting as soon as possible. (we are awaiting confirmation of dates for same)	Ongoing governance via regional management and the SEN team will allow for more robust procedures in place to ensure that multi-disciplinary meetings are held and recommendations from case reviews/SERGs are followed through in a quicker timescale to address outstanding issues between the young people, and ensure that all parties are satisfied with

			risk management plans and interventions.
5	The registered provider and director of care and quality must ensure that effective processes and resources for external auditing including of the centres approach for managing behaviour that challenges, as required by the National Standards for Children's Residential Centres, 2018 (HIQA) are put in place.	The registered provider is reviewing the auditing process and will be introducing the auditing system software early in 2022. All areas for oversight and service improvement will be raised to the Governance Committee for implementation of same.	The new auditing system software in conjunction with the recruitment of a second Compliance Officer will ensure there is a robust auditing system in place across the organisation.
	The registered proprietor and the director of quality and care must ensure that the intended governance framework of service improvement and shared learning is fully realised and that responses to high level escalations from the centre level are clearly documented from the governance committee level.	The escalation policy framework is with the governance committee for ratification and will be rolled out to all teams following the management support meeting on the 17.2.2022. The governance High level escalations realised will become a permanent agenda item on the governance committee meeting from the 24.2.2022	Reports of monthly data across the organisation will now include any aspect where high level escalation had to be initiated. This will allow for discussion with the committee and formal feedback/action plans will recommended as required. This will be recorded on the minutes of the meeting.
	The director of care and quality must ensure that the policies and procedures are updated without delay to include essential improvements in policy	The organisation has a full set of functional policies and procedures. As with each inspection that takes place throughout the organisation, these will be	As part of monthly management support meetings, home management teams will highlight in this forum if there are any policies which require an update. The regional team will forward same to the

	including procedures for anti-bullying responses, risk management and escalation procedures.	reviewed on a regular basis to ensure updates and ensure that guidance from R&I has been implemented. The policy & procedure subcommittee are meeting on the 11.2.2022 for a full day to review the current set of policies and highlight those that need brought into line with immediate effect. The risk management framework will be operational by the 1.3.2022 and the new auditing system in place by the 1.4.2022. A full review of all policy and procedures will be completed by the 30.6.2022. to ensure a robust review.	subcommittee of the policy & procedure group, who will meet monthly to review same. The governance committee also meet on a monthly basis and policies are ratified at this committee and also recommendations are given for policies which require review
	The centre manager and the regional manager must ensure that the level of risks identified from pre-admission risk assessment processes are fully taken account of when determining thresholds for admissions. Learning from previous admissions procedures must be included in a centre quality improvement plan for 2022.	The centre manager and regional manager will ensure the level of risks identified from pre-admission are highlighted on the group impact risk assessment and carefully considered prior to admission. The preadmission risk assessment will now encompass our new risk management framework which is currently being rolled out to all management teams and staff within the organisation. Regional	As part of the quality improvement plan for 2022, learnings will be learning outlined and shared with all relevant personnel. Home management teams and relevant personnel internally involved in pre admission risk assessments will ensure that multi-disciplinary consultation is held with all relevant social work departments.

		management and management teams have already received this training on the 20.1.2022. Currently there are another 3 scheduled training days on the 4/10 & 24.2.2022	
6	None identified		