An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 100

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Three young people**
Type of Inspection:	**Thematic Announced**
Date of inspection:	**17th and 18th November 2021**
Registration Status:	**Registered from the 31st January 2021 to the 31st January 2024**
Inspection Team:	**Cora Kelly** **Lorraine Egan**
Date Report Issued:	**12th April 2022**

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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 of January 2006. At the time of this inspection the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions from the 31st of January 2021 to the 31st of January 2024.

The centre was registered to provide care for three young people aged eleven to sixteen years on admission, on a medium to long term basis. The centre had a clear statement of purpose that stated its therapeutic practice model was trauma and attachment informed based on six modules; developmentally focused, competence centred, family involved, trauma informed, relationship based and ecologically oriented. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

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

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 17th of December 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The director of quality and care returned the report with a CAPA on the 11th of January 2022. A further revision of the CAPA was completed with the final CAPA received on 24th of January 2022. The centre was written to on the 3rd of March 2022 proposing to attach a condition to the registration of the centre as it was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III Article 7 *Staffing* as the centre has been unable to maintain a consistent staff team as a result of high levels of staff turnover. The condition being :

- There must be no further admissions of a young person under 18 to this centre until there is evidence of the availability of consistent and stable staff team having regard to the number of children residing in the centre and the nature of their needs.

The centre was written to on the 12th of April informing them that the condition has now been attached to their registration of the centre from the 24th of March 2022. This condition will be reviewed on or before the 30th May 2022.

As such it is the decision of the Child and Family Agency to register this centre, ID Number: 100 with an attached condition from the 31st January 2021 to the 31st of January 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

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

The following policies were reviewed as part of this standard; the centre's policy on care planning, placement planning, keyworking and emotional and specialist support. It was evident that efforts were being made by the centre to ensure that the young people were receiving good individual care and support. Improvement was required with respect to the centres policy on care planning.

There was an up-to-date care plan on file for one young person with their statutory child in care review (CICR) meetings being held in line with regulations. For the second young person their care plan had expired by three months at the time of the inspection. Their last statutory CICR was held in March 2021. In interview, their social worker had not recognised that the CICR was outstanding. Neither had the deficit in care planning been realised by centre management, staff or senior management through auditing processes or regional manager visits. The CICR was held three days after the onsite inspection. Operationally, the centre's care planning policy did not include mechanisms for escalating issues of this type to senior management, allocated social workers or management within social work departments. Further, statutory CICR review timeframes were not stated in the care planning policy. Rather, a broad statement was contained referencing that a principle of the organisation was to review the plan within the regulatory timeframe.

In terms of quality the current and outdated care plans was mixed. For one of the young people the inspectors found that their care plan contained a good analysis of their assessment of needs and an action plan. For the second young person, there was little information relating to them in terms of risks and behaviours and future planning as their aftercare plan was not yet developed. It was evident that the young people were supported to attend their CICR's and state their views. One of the young people attended their reviews and their views were sought across all areas discussed at the meeting. The second young person did not attend their reviews. In these

instances, their keyworker supported them in completing pre meetings forms. Social workers provided feedback from the meeting to them.

Consistency was found in young people having either individual placement plans (IPP's) or individual development plans (IDP's) that were used by the centre to plan placements and meet the goals of the placements. The IPP's were based on young people's care plans and other needs identified by staff. It was evident that some of the goals contained in the IPP's reviewed by the inspectors were being met with others ongoing without review. A function of the IPP system was for it to inform the day-to-day routines and future planning for both young people. It was the inspectors' findings that improvement was required for these areas. For the longest resident their day-to-day routines need to be strengthened to include more robust education related goals and in addition to this, specific interventions are required to support their day, night and sleep time routines. For the second young person there was little reference with respect to aftercare planning, they are to turn eighteen years old eight months post-inspection. This ties closely to deficits in care planning and CICR's where focus needs to be placed on aftercare, which is the primary need for the young person at this time.

In line with policy, mechanisms in place to discuss IPP's consisted of monthly team meetings that included attendance of members of the organisations clinical team and at daily handovers. However, reference to their individual plans was not consistently evident at the team meetings. It was not possible to get a sense of what was discussed in relation to the young people as placement plans, specific goals or outcomes were not reflected on the sample of minutes reviewed by the inspectors. In contrast, staff in interview described clearly examples of some of the goals contained within the IPP's.

Keyworkers held responsibility for completing monthly summaries that were forwarded to social workers. Having reviewed a sample of the monthly summaries the inspectors found that the format was good, the content recorded was comprehensive, but they were not connected to the young people's IPP's. The inspectors recommend that the template is reviewed to ensure it connects with the IPP's. It was evident that both young people had good relationships with their keyworkers and stable members of the staff team. In interview staff members were clear of their roles and responsibilities as keyworkers, there was evidence of good work though across keyworking records. Young people were encouraged to participate in the development and ongoing implementation of their placement plans. The approach to keyworking was child focused and child led.

There was good evidence of clinical input being provided to the staff team to guide their approach to providing care to both young people. The individual therapeutic plans (ITP's) were found to be comprehensive, practical and staff stated that the ITPs were helpful and clear. The contact arrangements in place with family was good. There was a focus on family access and staff supporting access arrangements that agreed with social workers in this regard. From the review of documentation there was evidence that there was good and regular communication from the centre to social workers.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
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 director of care and quality must develop the care planning policy to include procedures for escalation and timeframes for when statutory child in care reviews meetings are required to be held.
- The centre manager must review the placement planning system to improve goal setting and review mechanisms to include better recording of discussions of placement and development plans at team meetings.

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.

There had been a change in centre manager since the last inspection in November 2020. The suitably qualified and experienced centre manager, as the appointed person in charge, held overall responsibility for the running of the centre. They were present in the centre Monday to Friday working normal office hours. Their input was evident across the inspectors review of centre records and young people's files. In interview, staff named that they were very supportive, approachable, and always available to them for advice and guidance. They demonstrated a good commitment to providing good care and support to the young people also, how they provided leadership and managed the centre and staff. The centre manager reported to the regional manager who regularly visited the centre to meet with them, staff and young people and review some centre records. They also provided the centre manager with supervision. It was evident that the regional manager was providing good support and leadership to them.

There were clearly defined governance arrangements in place and staff interviewed were aware of the management structure and of individual roles and responsibilities. Governance responsibilities included the centre manager attending monthly management meetings and completing weekly operational reports, HR reports and internal audits. They identified in interview that auditing was an area that required improvement. The centre manager held responsibility for completing monthly internal audits and providing them to the regional manager and the organisation's compliance officer. The latter were tasked with providing feedback on the audits to the centre manager. This has yet to take place. The inspectors found from the review of audits completed to date this year that areas of non-compliance were not formulated into an action plan for implementation within a specified timeframe. Further, as a quantitative approach to completing the audit was taken the inspectors could not determine how the criteria within the standards were deemed compliant. For some areas, narrative on the standards did not correlate with areas of compliance identified. This was also found by the same inspectors during an inspection of a

sister centre in September 2021. An external audit had not been completed by the compliance officer nor was their role referred to at the management meeting held in the previous month.

There was a service level agreement in place with the Child and Family Agency for the provision of services with the contract signed mid-2021.

A sub-committee within the organisation held responsibility for ensuring that the centre's operational policies and procedures followed the requirements of regulations and the national standards. They were last reviewed in August 2021 with some policies updated and others currently at draft stages of development. However, from the policies and procedures reviewed as part of this inspection further updates are outstanding. Overall, notwithstanding the requirement for regular reviews, the organisation has not yet reached a stage of having fully implemented policies and procedures aligned to the National Standards for Children's Residential Centres, 2018 (HIQA) since the Alternative Care Inspection and Monitoring Service commenced its inspections against the national standards in November 2019.

The internal management structure was not appropriate to the size and structure of the centre. The centre and deputy managers were supported by two trainee senior practitioners. They had yet to complete the senior practitioner programme. The acting deputy manager was the appointed person to step up into the centre managers position during their time off. There was a staff responsibility record in place. A written delegation of tasks record was set to be implemented within the organisation following the inspection a copy of which was provided to the inspectors.

Centre management and staff described in interview the risk management framework in operation and from this had a good understanding of the processes for the identification, assessment and managing of risk. Individual risk assessments, individual crisis support plans, absence management plans, pre-admission risk assessments, impact risk assessments were elements of the risk management framework. Some improvement to the risk management framework was deemed required. The absence management plan for one young person was not adequate to manage risks during their extended planned time away from the centre. The absence management plan requires expansion in consultation with the social work department to include a risk assessment or safety plan.

At the time of the inspection the inspectors were not able to determine how risk levels were decided and when they are escalated externally. Information on the draft

individual risk management planning policy and procedures was provided to the inspectors following the onsite piece of the inspection. The centre's risk management system was not implemented.

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 director of care and quality must develop an effective auditing system without delay, one that encompasses internal and external auditing processes and leads to service improvement. Training must be provided to centre management on how to conduct internal audits and there must be better communication between all personnel with auditing responsibilities.
- The director of care and quality must ensure that fully functional policies and procedures, that comply with HIQA National Standards, are in place immediately.
- The director of quality and care must ensure that an internal management structure is in place.
- The centre manager must ensure that processes are in place that adequately manage young people's individual risks.
- The centre manager must ensure that internal significant event reviews take place.
- The director of quality and care must ensure that a risk management system is implemented without delay.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

There was evidence of workforce planning through discussions at monthly management meetings, staff rota, provision of ongoing professional supervision and training and development. However, the mechanisms in place by the organisation to plan, organise and manage the centres workforce were not proving effective and that had resulted in child-centred practices not being delivered. Current members of the staff team had experienced staffing challenges and frequent periods of low morale, feeling the impact of working with less experienced and newer members of staff.

The composition of the current staff team in the centre included a centre manager, a deputy centre manager, two senior practitioners in training one of whom worked 30 hours weekly, six full-time social care workers and a social care worker who carried out 30 hours work per week. The centre managed stated that there was one social care worker vacancy with a second arising at the end of November 2021 due to the staff member relocating. This person was a keyworker to one of the young people. Relief staff were not available to support the staff team and cover the varying types of leave. Daily shift ratios included two staff completing 24-hour sleepover shifts and a day support staff.

Since the last inspection in November 2020 the inspectors found that a consistent staff team had not been in place in the centre in line with the centre's statement of purpose and to meet the needs of the young people in placement. The rate of staff turnover was high. There had been a change in centre manager and deputy manager positions had changed twice. There was also a bereavement that impacted hugely on the staff team and young people. A further nine staff had left their positions with lengthy travel times, changing sector, transfers to other centres within the organisation including promotions, being cited as reasons for this turnover. The effect of this was impacting on a continuity of care and staff stability being provided to the young people in placement as external staff were being sought to complete shifts. This was in addition to centre management also completing shifts. The movement of staff between centres within the organisation was a regular occurrence with both young people voicing their unhappiness about it as both struggled with

newer staff members. It was the inspectors' findings that the practice was impacting on their behaviour in the centre as it corresponded to incidents in behaviour escalation. To date this year a total of 19 staff from seven other centres completed shifts in the centre on 35 occasions. Even though the centre was experiencing staffing issues six staff from the centre completed shifts in four other centres on 22 occasions. It was evident from the inspectors review of monthly summaries, exit interviews and significant event review meeting records that senior management had identified that staffing deficits was impacting in a consistency of approach being implemented and that the issue needed to be addressed.

Deficits relating to recruitment and selection and training were identified by the inspectors. Staff were provided with training at the induction stage of employment. A training needs analysis was maintained, and deficits were found regarding training that some staff had yet to be provided with. Child protection, model of care and fire safety were the identified types of training. Onsite fire safety training that includes the safe use of firefighting equipment must be secured.

The centre had a policy on staff retention. It was outlined in the policy that staff retention was recognised as the foundation for implementing its trauma and attachment informed model of care. The challenges posed by staff deficits did not comply with this approach. Staff retention measures included training, supervision, pensions scheme and maternity leave benefit. However, these alone were not proving to be effective.

The centre manager and staff in interview described the policy and guidelines for on-call and of the formalised procedures in place. There were no concerns or issues regarding on call arrangements identified to the inspectors.

Standard 6.2 The registered provider recruits people with required	
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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The director of quality and care must conduct a review of their workforce planning strategies and ensure that there are always appropriate numbers of staff employed in the centre to meet the needs of the young people.
- The director of quality and care must implement measures that prevents the movement of staff from the centre to facilitate staffing deficits within the organisation and not impact on the care being provided to the young people.
- The director of quality and care must ensure that qualified and experienced relief staff are available to support the staff team.
- The centre manager must ensure that training deficits are addressed including onsite fire safety training.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The director of care and quality must develop the care planning policy to include procedures for escalation and timeframes for when statutory child in care reviews meetings are required to be held.	The director of care & quality has met with the regional team who have now devised to review care plans at each monthly visit in conjunction with the home managers to ensure deficits are promptly identified and corrected. This is now in place with immediate effect in line with new systems that have been implemented as part of a regional manager's home visit. Evidence of this has been submitted to the inspectors.	The policy subcommittee team are due to meet on the 11.1.2022 as part of the next policy and procedure review and will devise an escalation policy to ensure prompt action occurs in relation to care review meetings are held and reports sent in a timely manner. Once complete this policy will be reviewed at the governance meeting on the 27.1.2022 for ratification.
	The centre manager must review the placement planning system to improve goal setting and review mechanisms to include better recording of discussions of placement and development plans at team meetings.	A new recording template has been devised, it will be ratified at the governance meeting on the 27.1.2022, so it can be implemented across the organisation from February 2022.	The home manager will ensure placement planning will be a permanent item on team meeting agenda and there is a clear 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.

5	The director of care and quality must develop an effective auditing system without delay, one that encompasses internal and external auditing processes and leads to service improvement. Training must be provided to centre management on how to conduct internal audits and there must be better communication between all personnel with auditing responsibilities.	The organisation is introducing a new auditing system 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.	The new system in conjunction with the recruitment of a second compliance officer will ensure there is a robust auditing system in place across the organisation. The new system will be operational in 8 – 10 weeks. The auditing position is currently being advertised; this post should be in operation by the 1.4.2022.
	The director of care and quality must ensure that fully functional policies and procedures, that comply with HIQA National Standards, are in place immediately.	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 further full review of all policy and procedures will be completed by the 30.6.2022 to ensure that robust policies and procedures are in place.	Systems are in place that allow the director of care to ensure that policies and procedures comply with HIQA National Standards. These include members of home management teams, regional team, and the policy & procedure subcommittee, who will meet monthly to review same. The governance committee also meet monthly, and policies are ratified at this committee and recommendations are given for policies which require review.
	The director of quality and care must	Both trainee senior practitioners have now	The director of care & quality alongside the

	ensure that an internal management structure is in place.	completed their training and one is now fully appointed with the second coming on board in January 2022. A further trainee senior practitioner is due to complete the programme in April 2022.	HR operations manager will continue to conduct monthly workforce planning meetings to ensure that enough staff are being recruited to fulfil these roles. Current recruitment has been completed for new trainee senior practitioners within the organisation and a new 1-year programme is due to commence in January 2022
	The centre manager must ensure that processes are in place that adequately manage young people's individual risks.	With immediate effect absence management plans alongside risk management plans will be robustly updated to reflect periods where young people are on extended periods of stay from the home.	The risk management framework will be reviewed regularly to ensure this new system is effective and guides the practice of staff.
	The centre manager must ensure that internal significant event reviews take place.	With immediate effect the centre manager will ensure that internal SERG's take place. The organisation is currently reviewing the significant events review process. This overhaul will encompass a review of learnings from significant events and how this impacts service delivery, firstly in the home with the staff team and	The review will initiate a triage process and return the focus and accountability of SERGS to the home managers in the first instance. The aim is to capture immediate learnings from significant events to improve service delivery. As part of the regional team's oversight of their homes, they will review the quality

		secondly for the overall company.	and consistency of the new format over the next quarter and feedback will be given to the director of care & quality monthly.
	The director of quality and care must ensure that a risk management system is implemented without delay.	A new risk management structure has been devised and the training for the implementation of it will begin in January 2022. The staff will be trained in same from February 2022, with implementation from the 1.3.2022	A consultant will deliver the training on the new system across the organisation to ensure consistency across the organisation. The risk management framework will be reviewed regularly by the regional team going forward following implementation to ensure this new system is effective and guides the practice of staff.
6	The director of quality and care must conduct a review of their workforce planning strategies and ensure that there are always appropriate numbers of staff employed in the centre to meet the needs of the young people.	With immediate effect and ongoing. Work force planning meetings happen weekly/ monthly in conjunction with regional management and HR to ensure there are planning strategies in place to facilitate appropriate staffing levels being met across the homes. Currently there is a consistent team in place within this home.	The HR department have a robust recruitment strategy in place to determine how best to meet the staffing requirements in the homes. The regional team will highlight monthly any major deficits in staffing to the director of care & quality.
	The director of quality and care must implement measures that prevents the movement of staff from the centre to facilitate staffing deficits within the	With immediate effect this team is to remain consistent and allocated to their specific home. The director of care and quality chairs workforce planning	Workforce planning meetings will occur on a weekly/monthly basis and will review all aspects of staffing within the home and in particular the movement of staff within the

	organisation and not impact on the care being provided to the young people.	meetings, considering movement of staff within the organisation and will endeavour to implement measures to prevent this occurring on an ongoing basis. (N.B Unfortunately, with the global pandemic that we are in, we are in the position that we do have to utilise staff from other homes at times. Where we do so, we try to ensure that these staff are familiar with the young people in the sister home to ensure a lesser impact on the young people)	organisation. The practice of utilising staff from other homes, will only be used in an emergency basis and regional management must be alerted if this arrangement is needed, to ensure sign off on same.
	The director of quality and care must ensure that qualified and experienced relief staff are available to support the staff team.	The director of care and quality will ensure the recruitment process includes recruiting relief staff specific to individual homes to promote consistency and are available to support the staff team. Currently there are adequate levels of bank staff to support the team where applicable	Currently there is a company bank list and each home will have a specific number of relief staff assigned to them. These staff will be directly line managed by the home management team to ensure consistency and stability within the staff team.
	The centre manager must ensure that training deficits are addressed including onsite fire safety training.	The training team will provide training in a timely manner to develop the skills and competencies of the staff. Regarding onsite fire training, one of the internal trainers are now trained in fire safety and	Home managers will receive a monthly report from the training department outlining a training schedule for their teams. All managers are aware of how to escalate training needs and how to request

		will be able to deliver this training to teams in person without delay (Covid restrictions permitting).	bespoke training for their home. Any ongoing difficulties securing training/or shortfalls in training are to be escalated to the regional manager.