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: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**02nd, 03rd & 04th November 2022**
Registration Status:	**Registered from the 31st January 2021 to the 31st January 2024**
Inspection Team:	**Catherine Hanly** **Lorraine Egan**
Date Report Issued:	**21st December 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 31st of January 2006. At the time of this inspection the centre was in its sixth registration and was in year two 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 as a multi occupancy service 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 was one child living in the centre at the time of the inspection. A second young person, that had lived in the centre for a significant period, had been successfully reunited with family members and returned to live at home the week prior to the onsite inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child centred Care and Support	1.6
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff. 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 24th of November 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 30th of November. This was not deemed to be fully satisfactory, and the inspection service requested additional information about the actions taken by centre management to correct deficits. This was subsequently provided in a prompt manner.

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: 100 without attached conditions from the 31st of January 2021 to the 31st of January 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

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

Inspectors found evidence that young people were listened to by the staff team and their views and preferences were taken into consideration in the weekly planning of meals and activities. There was evidence in key working records and individual work of open discussions with young people regarding their day-to-day planning in the centre. The main forum for discussion and planning was at the young people's weekly meeting, however inspectors noted in team meeting minutes that, for some time, staff had been commenting that the young people's meeting was not always well-engaged in and was described as 'not working well'. This reflects a similar finding in a recent inspection of another centre operated by this organisation. Inspectors recommend that the manager and staff team create other opportunities to achieve the identified purpose of the young persons' meeting.

There were some aspects of goal planning completed in an appropriately child-friendly manner by members of the staff team and recorded in key working on the child's file. Inspectors reviewed the placement plan of the current resident and found that the views of the young person within their own care and placement planning could be strengthened and included to a greater extent. This also reflects the same finding as in the recent inspection already referred to.

The centre had a clear policy on complaints that was updated most recently in June 2022. This was consistent with relevant legislation and best practice and distinguished between notifiable and non-notifiable complaints. Inspectors were informed during interviews and viewed in team meeting records that the complaints policy had been discussed at the team meeting the day prior to the onsite inspection. Staff interviewed clearly understood the practice of hearing and responding to formal complaints by young people but couldn't describe clearly in its entirety, the policy, or the process around non-notifiable complaints, including the use of the complaints register. The centre manager must ensure the staff team have a sufficient working

knowledge of all relevant policies. Overall, inspectors found good records relating to notifiable complaints made by the previous resident of the centre and good evidence of reporting these matters to their social worker and family. The length of time taken to conclude complaints was unacceptably long – some took twenty months – far exceeding the timeframes indicated in the centre policy document. Whilst records showed evidence of the centre manager liaising regularly with the social work department to seek updates on the status of complaints, there was no evidence of the lack of closure being escalated internally or externally because of review at the significant event review forum. The complaints records reviewed by inspectors didn't show evidence that the young person was being kept updated throughout the process although inspectors were consistently informed in interviews that this does happen as required by policy. The centre manager must ensure that any pertinent updates provided to the young person on the status and processing of their complaint is stored with the complaint record itself for tracking purposes. Inspectors were unable to ascertain from the records reviewed how the complaint was resolved and it appeared to be more because of the passing of time that the issue became no longer as relevant to the young person. The centre manager informed inspectors that an external advocacy service was engaged by the young person to support them in their complaint, however the evidence of this was not with the records of the complaint itself. Records of complaints must be clearly maintained and updated to identify what action was taken, by whom, and when.

Inspectors found little evidence of the detail of informal complaints on file, aside from four entries in the centre register, the most recent of which was from February 2021. It was not evident to inspectors how non-notifiable complaints were being recorded, responded to, or managed at the centre with learning generated from same. This is an area that requires attention by the centre manager to ensure there is robust practice in this area based on openness and transparency.

Inspectors found that the young person who had made several formal complaints at the centre had their feedback sought on their experience of using the complaints process. However, this feedback was sought a significant length of time after the complaint had been made and therefore had potentially little meaning for the young person. Feedback should be sought much closer to the time of the young person using the complaints process so that they can give meaningful feedback based on their experience.

Young people were informed about their right to complain on induction and the young person currently residing at the centre confirmed this when they spoke with

inspectors. This information was again provided during key work and at young people's meetings, along with information on external advocacy services such as EPIC and VOYPIC. During conversation with inspectors, the child expressed their clear understanding of their right to complain and were confident that any member of staff would listen to what they had to say.

Following a recent inspection in another centre, management committed to creating an addendum to the young person's booklet with more information relating to the complaints process. Inspectors were informed that this was a work in progress at the time of this inspection and would be provided upon completion. The parents' booklet includes information on their right to and process for making a complaint.

Inspectors reviewed a report based on an audit completed by the organisations' audit compliance manager. Inspectors were unable to ascertain from this audit how the application of the complaint's policy and process was determined to be compliant as this level of detail was not included in the report. Where a deficit was identified in this report, a correlating corrective action was not consistently stated or identified. It was acknowledged by the regional manager with responsibility for this centre, and separately by the director of governance, quality, and strategic development that this continues to be an area of work in progress and inspectors concur that it requires development.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **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 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure the staff team have a sufficient working knowledge of all relevant policies.

- Centre management must ensure that there are appropriately robust systems in place that facilitate timely management and complete recording of all complaints made.
- Senior management must ensure that there is regular review of the complaints process and implementation of any learning arising from such review through the operation of appropriately robust oversight and governance systems.

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.

Inspectors found that governance arrangements and structures were clearly defined in organisational documentation and understood by senior management. The centre manager reported to a regional manager; policies and procedures were reviewed by an identified subcommittee and circulated to the centre for review and implementation; weekly operations and human resource reports were submitted by the centre manager to the regional manager and the HR department for review and response as necessary; senior management and separately governance meetings were convened on a regular basis where the operation of the centre, amongst many other things was discussed. The regional manager described their role which included providing formal supervision to the centre manager, as well as being readily available during the working week, and visiting the centre on a regular basis to engage with staff and to formally review records and practices on occasion. The staff members interviewed could not readily describe lines of authority and accountability or clearly name governance or auditing systems in place or the impact of such systems on their work at the centre.

The centre manager was the named person in charge of the centre with overall executive accountability, responsibility, and authority for the delivery of the service. They had been in post just over two years and worked normal office hours Monday to Friday and demonstrated to inspectors how they delivered on their responsibilities

including oversight of care records at the centre, liaison with professionals, and supervision of half of the staff team. The staff and the regional manager for this centre described the centre manager as being a strong leader in the centre, overseeing practice and guiding the work as necessary. Staff interviewed spoke more about the individual role and responsibility and the team approach in the centre with the discussion and agreement of tasks at handover for example or use of initiative in delivering on practice as opposed to being led or guided in their practice. Inspectors were provided with samples of governance meetings that had been convened at senior management level during the past six months. However, corresponding team meeting minutes noted that either there was no governance meeting or that there was no feedback for the staff team. Inspectors recommend that senior management take action to ensure that there is a clear understanding and awareness at staff team level of the governance arrangements and structures for this centre which include lines of accountability and their impact on the direct work of staff. They must also satisfy themselves that communication structures and systems within the organisation are effective and purposeful.

The regional manager with responsibility for this centre confirmed with inspectors that the centre has a service level agreement in place with Tusla and that six-monthly reports of progress are submitted to Tusla.

As previously stated, a sub-committee within the organisation held responsibility for ensuring that the centre's operational policies and procedures were compliant with the requirements of relevant regulations and the national standards. The policies and procedures had most recently been updated as an entire document in June 2022. Further, a rolling system of policy review was in operation, with identified policies scheduled for review named in senior management meeting records. Upon review, policies were issued out to the centre and the manager made them known to the staff team. Staff members were expected to read the updated policy and sign as having done so. As mentioned under standard 1.6, the manager had recently commenced a practice of reviewing policies at team meetings also, although the effectiveness of the current review process may need further development. Inspectors found that the policies and procedures reviewed relevant to inspection were up to date, and the entire suite of policy documents had been updated in June 2022.

Deficits in risk management system had been identified at the last inspection of this centre one year previous. Inspectors found at this time that improvements and developments, as committed to in the last inspection report, had been realised at this time. Risk identification and the management of risks were better understood

following the introduction and application of a group risk matrix which guided the identification, management, and escalation procedures necessary. This risk matrix was accompanied by pre-existing group impact risk assessments to determine suitability of admissions, individual crisis management plans, absence management plans and a revised, more comprehensive individual risk assessment document that was updated on a regular basis. Inspectors found that risks were categorised and discussed at governance meetings with relevant learnings identified. The centre maintained a risk register and staff were familiar with this. There was an on-call system in place and staff were aware that the regional manager could be contacted in an emergency if identified on-call were not available for some reason. Inspectors reviewed a sample of significant event review group meetings and found that the content in terms of analysis of the event and interventions was of a high standard, was theory-led as well as providing good practical guidance on alternative strategies or interventions to the staff team. Additionally, there was evidence of the findings from these reviews being consistently brought back to team for discussion and implementation which contributed to the reduction of risk. Inspectors did note that some of the recommendations included basic guidance on care/nurturing approach, and which is basic knowledge the staff team should already have or if not, should be readily guided by the centre management. This is a finding that should be considered in the context of standard 6.4 – as it relates to staff competency – detailed further on in this report.

The internal management structure consisted of centre manager, supported in their duties by a fulltime deputy manager. There was one social care leader and a further two in an internal training programme to become social care leaders. The existing social care leader had the requisite three years' experience at social care level however the trainee social care leaders did not. Senior management must ensure that the appointment of staffing is in accordance with the memo issued to providers which includes the requirement for social care leaders to have three years' experience at social care grade. There was evidence of tasks delegated to identified persons and the deputy manager provided cover in the centre managers absence. In the previous inspection report, centre management had committed to securing three social care leaders to this centre and this remains a piece of work ongoing.

Inspectors found that an effective auditing system had yet to be realised at the centre with developments to achieve this ongoing. This had been identified as an area of action during the last inspection. The centre manager was responsible for completing internal audits and providing them to the regional manager and the organisation's compliance officer. Inspectors found that these internal audits did not always name a

clear action or specify a timeframe for action. Additionally, although the audits were conducted regularly, one deficit relating to a lack of records from the social worker of statutory visits with the young person not being on file had not been picked up for a period of four months. The efficacy of this system needs to be reviewed by senior management.

A new compliance officer had been appointed in early summer 2022 and they were responsible for conducting themed audits against the national standards in each of the centres within the organisation. The inspectors reviewed a sample of audits conducted that were inclusive of the standards examined during this inspection. An audit had been conducted of theme 5 but no actions were identified. A separate audit of theme 1 had been conducted with some areas of non-compliance identified. Where the non-compliance was named, there was not always a clear action stated to address the named issue. Where actions were identified, there was no timeframe for action specified. Further, the approach to completing the audit was quantitative therefore inspectors were unable to determine from the audit report itself what aspects of records or interviews had been undertaken to inform the audit and how it was determined that the standards were deemed compliant or not. Additional explanatory information may be of benefit to centre and senior management.

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

- Senior management must take corrective action to ensure that there is a clear understanding and awareness at staff team level of the governance arrangements and structures for this centre which include lines of accountability and their impact on the direct work of staff. They must also satisfy themselves that communication structures and systems within the organisation are effective and purposeful.

- The director of care and quality must fully implement an effective auditing system without delay, one that encompasses internal and external auditing processes and leads to service improvement.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

A formal induction policy and practice were in place that had recently been reviewed. Based on this review, it had been agreed to extend the formal induction from two to three weeks to allow necessary time for familiarisation with all relevant policies and procedures and to complete the necessary mandatory training including fire safety awareness, Children First online E-learning module, and training in the implementation of crisis intervention and prevention. Inspectors were informed about adaptations to the induction programme to cater for identified needs of new staff onboarding.

There was evidence of attention to ongoing training and development opportunities for the staff team recorded at supervision, team meetings and at senior managers level in their meetings and in governance meetings. Inspectors found that there was a programme of mandatory training with refresher training in these courses regularly communicated by the training department and overseen and recorded by the centre manager. Onsite fire training, identified as an area of training in the inspection one year ago, had been attended to by centre management. In addition, safeTALK and ASIST training were provided to the staff teams across the organisation. Staff in the centre were facilitated, encouraged, and supported to attend training by centre management and the participation at this had been made easier by the stabilisation of the staff team in the previous six months. Despite this, inspectors also seen references to staff not attending training that they were booked on, dropping out of commitments to training at the last minute, and on one occasion a trainer having to pause training due to non-attention by the participants.

Inspectors noted multiple references in various records to a training needs analysis but could not actually find evidence that a formal and robust needs analysis specific

to the staff team in this centre and the young people they were working with had been completed. Additionally, in different records and at different times, training needs outside of the mandatory and rolling training programme were identified including report writing and key work training. The former of these was to be rolled out for all staff, as committed to at senior management level, in September 2022 but this had not yet been realised. Inspectors noted, as previously commented upon, that some of the learning and feedback arising from significant event reviews related to basic care and nurturing of children. This finding should be given due consideration in the training needs analysis.

Inspectors recommend that senior management conduct a formal and robust training needs analysis for the staff team and manager in this centre. This needs analysis must give due consideration to levels of competency – ability to carry out their role effectively utilising their training and learning – across the staff team as required across relevant areas, as well as professional development for the centre manager that would support them in their role. Centre management must then implement a programme to meet the specific professional development and training needs arising from this needs analysis.

Compliance with Regulation	
Regulation met	**Regulation 6 & 7**
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 6.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- Senior management must conduct a centre-specific training needs analysis and devise a programme of intervention with the necessary resources to address any identified needs.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager must ensure the staff team have a sufficient working knowledge of all relevant policies.	The Centre manager reviews a schedule of policies at every monthly team meeting. With immediate effect, during this process the home manager will ask competency-based questions to satisfy themselves that staff fully understand the policy and procedure being discussed. The next team meeting is scheduled for 02.12.22 For staff who are not in attendance at the meeting, the home manager will ensure they have received the same information and are asked questions to satisfy competency in policies reviewed. Following the inspection, the home manager reviewed the complaints policy will all staff on daily handover to ensure their understanding of same. The complaints policy will be reviewed again at the next team meeting which is scheduled for 02.12.22. The home manager will	The Home Manager will continue to review policies via their team meetings , this will occur monthly whereby competency questions will be asked to demonstrate knowledge of the team. (Monthly) All staff will be made aware of their accountability and responsibility re same. The organisation are rolling a Time Management System (TMS), which will have a link to all up-to-date policies and procedures – where an update is made to a policy, each staff member will receive an notification and will be required to confirm that they have read and understood said policy. This system will be rolled out in January 2023. Any updates to policies will also be communicated to the team via informal supervision process.

		satisfy themselves that the team are fully up to date on the full complaints process through asking competency-based questions.	Compliance officer as part of auditing role will speak with staff and test knowledge on relevant policies including complaints process. As part of the regional managers visits to the home, temperature check staff knowledge by asking them to explain their knowledge on key policies.
	Centre management must ensure that there are appropriately robust systems in place that facilitate timely management and complete recording of all complaints made.	With immediate effect, the home manager will ensure any complaints that are made are followed up in a timely manner that is in line with policy. Any complaints received will be submitted to the Regional Manager via the weekly reporting structure whereby progress on the complaint will be reported on until it is closed out. With immediate effect, all information pertaining to a complaint, the process of investigating the complaint and all follow up measures will be documented and placed on file. The home manager will ensure that the young person is kept up to	The compliance officer will complete audits in the home to ensure compliance with relevant policies, including complaints and that they are responded to in a timely manner. The regional manager, as part of their visits to the home will temperature check that complaints are being processed in line with policy. This will also be monitored via the weekly report process.

		date on the status of their complaint which will be evidenced on file. Where a complaint has been closed, the home manager will ensure feedback is sought from the young person to ascertain if they are satisfied with the outcome. Where they are not satisfied with the outcome the young person will be informed of their right to appeal. Any complaints not resolved within a 21 day period will be escalated to regional management for further action.	
	Senior management must ensure that there is regular review of the complaints process and implementation of any learning arising from such review through the operation of appropriately robust oversight and governance systems.	15.11.22 The complaints policy was reviewed in full with recommendations made to enhance governance and oversight regarding the process to ensure complaints are dealt with in line with policy and timeline of same. The updated policy includes details of recording, timelines, investigation and where learnings are identified, how these are shared within the organisation. The policy will be sent to the governance committee scheduled for 15.12.22 for	As part of the complaint policy review, a senior social worker has been appointed to maintain a database of complaints and track their progress to ensure they are addressed in line with policy.

		ratification.	
5	Senior management must take corrective action to ensure that there is a clear understanding and awareness at staff team level of the governance arrangements and structures for this centre which include lines of accountability and their impact on the direct work of staff. They must also satisfy themselves that communication structures and systems within the organisation are effective and purposeful.	With immediate effect, the regional manager discussed the governance structures in place in the centre with the home manager. 02.12.22 The home manager will complete a review of the Governance Structures withing the organisation with the staff team. This will include roles and responsibilities of each department and the support and escalation structures. The home manager will facilitate questions and answers to ensure the staff team fully understand the structures in place. With immediate effect, where a new staff member joins the team, the home manager will ensure they are fully informed of the governance structures in place.	As part of regional managers visits and the compliance officers' visits to the home, they will temperature check with staff their knowledge of the governance structures and supports in place including reporting lines and escalation.
	The director of care and quality must fully implement an effective auditing system without delay, one that encompasses internal and external auditing processes and leads to service improvement.	A compliance auditor is fully operational and is currently utilising a new auditing system. The Director of Quality and Governance is working alongside the new compliance officer to ensure audits are being completed effectively. With	Where audits are being completed the Director of Quality and Governance will complete reviews on the quality of the audits to satisfy themselves that sufficient evidence is being reviewed to justify the judgement been given. Due to this being a

		immediate effect, the compliance auditor with the support of the Director of Quality and Governance will ensure that where learnings are identified, these are being addressed, learnings may also be shared at an organisational level if/where deemed appropriate. All Home Managers also have access to this system whereby they can complete internal audits to ensure compliance.	new system, the Director of Quality and Governance will continue to work closely with the compliance auditor to ensure the system is working effectively and leads to overall service improvement. Any trends or patterns being observed will be brought to Governance committee for review whereby an action to address same will recommended.
6	Senior management must conduct a centre-specific training needs analysis and devise a programme of intervention with the necessary resources to address any identified needs.	By 31st January 2023 a centre specific training needs analysis will be completed for the home.	The training department will oversee the training needs for the overall organisation. The home manager will monitor renewal dates for staff to ensure staff are up to date and enrolled on mandatory and bespoke training when required. The training department will also be monitoring renewal dates for each home whereby refresher training will be scheduled in line with assessed need.