An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 191

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Ashdale Care Ltd**
Registered Capacity:	**Three young people**
Type of Inspection:	**Blended announced**
Date of inspection:	**14th and 15th September 2021**
Registration Status:	**From the 14th of May 2021 to the 14th of May 2024**
Inspection Team:	**Cora Kelly** **Catherine Hanly**
Date Report Issued:	**18th November 2021**

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

The centre was registered to provide specialist residential care for up to three young people aged 12-18 years with complex emotional and behavioural problems who cannot be cared for in a mainstream residential setting. A person–centred therapeutic service was the model of care utilised in the centre. 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
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

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, 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 12th of October 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 2nd of November 2021. This was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 191 without attached conditions from the 14th of May 2021 to the 14th of May 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

The centre had a child protection and welfare policy and procedures document that, upon review by the inspectors was found to have complied with the requirements outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015. Policies relating to reporting procedures, protected disclosures, lone working, anti-bullying and complaints were contained in the policy document. Elsewhere, there were policies and procedures relating to family time, connections with friends and electronic communication that included procedures for responding to and managing possible exploitation on the internet and social media. There was an appropriate child safeguarding statement and a letter of compliance to say it had been reviewed and approved by the Tusla Child Safeguarding Statement Compliance Unit. The statement was available to view in the staff office. As required, a list of mandated persons was maintained by the centre manager. It was provided to the inspectors and was deemed appropriate following their review.

The centre manager, as the appointed designated liaison person (DLP) had been provided with relevant DLP training. A date had been scheduled for a senior staff member as deputy DLP to attend the training. Safeguarding training that was provided internally by the organisation was based on their own child protection policies and procedures. There was an additional mandatory requirement that all staff complete the Tusla E-Learning module: Introduction to Children First, 2017.

Following the inspectors review of questionnaires, centre records, young people's care files and information gathered during interviews it was found that improvements were required around both centre management and staff's knowledge and understanding of child protection procedures. Further, improvement is required regarding the organisation's governance arrangements in ensuring that the centre is operating in compliance with its own safeguarding policies and procedures. It was found from the review of questionnaires that staff struggled with naming policies relating to safeguarding. Of a staff team of eleven, including the centre manager four

staff had not completed child protection training. All staff had completed the above-mentioned online e-learning programme. Through questionnaire a few staff members appropriately identified the whistleblowing policy if they were to address poor practice. However, others did not refer to the policy despite it being regularly recorded as being discussed at team meetings.

Improvement is required with respect to centre management and staff's knowledge in recognising and reporting child protection concerns and their awareness of their responsibilities as mandated persons. Through questionnaire some staff, including those that had been provided with child protection training, were not clear on the procedures to be followed for child protection concerns that did not reach the threshold for reporting. The inspectors recommend that the child protection policy is clearer with respect to this.

The inspectors found from their review of the centre's child protection and welfare register that four child protection and welfare reports had been appropriately reported to Tusla through the online portal system. However, they identified from their review of one of the young people's care files that a child protection and welfare report had not been submitted for one young person where a child protection concern existed. This Information had been sent in the form of a significant event notification that was promptly submitted to identified professionals internally within the organisation and to the young person's social worker. However, concern arises for the inspectors as the child protection concern had not been identified and reported by the centre in line with their mandated responsibilities and the matter was not identified by the organisation in a timely manner. Senior management did identify it as a matter that should have been reported during a significant event review meeting that occurred three weeks later. Senior management must ensure that all staff are provided with child protection training, satisfy themselves that all centre staff have a clear understanding of the various reporting procedures in place and that governance structures identify child protection concerns in a timely manner.

There was evidence of centre management and staff working in partnership with social workers for the current young people. Social workers for both young people stated in interview with the inspectors that centre management and staff worked collaboratively with them through regular communication and seeking their input on aspects of care being provided. The inspectors found that the young people were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. There was evidence of young people being supported by staff and keyworkers in keeping safe. This work was completed in line

with their individual development plans with keyworking records evidencing it. In interview a young person stated that they felt safe in the centre and through questionnaire both young people named staff they could talk to. Young people were encouraged and supported by management, staff and social workers to speak out if they were feeling unsafe or vulnerable.

As part of the admissions policy young people's individual areas of vulnerabilities were identified at the referral stage of admissions namely though the pre-admission risk assessment process that is managed by senior management in the organisation. The process involved pre-admission risk assessments being completed with areas of risk being identified and plans put in place to manage the risks. The completion of impact risk assessments followed this process. Such documents were for completion by centre management with internal clinical input and in consultation with social workers the purpose being to assess the levels of risk for the young person being considered to move to the centre and those already resident. Whilst clear processes were in place the inspectors identified that significant safeguarding concerns existed with respect to the first young person admitted to the centre, who previously resided in a sister centre, and who was discharged from this centre after eleven days. The inspectors were of the view that sufficient information was known to the senior management about the high-level risks presented by the young person and that mechanisms would not be robust enough for the safety of that young person and another young person who moved to the centre during the young person's eleven-day placement. Following the emergency discharge senior management conducted a review of the placement with a purpose to extract learning and recommendations. Of the three-recommendations outlined in the report two related to pre-admission risk assessment processes already in place. Senior management must ensure that the level of risks identified from risk assessment processes and discussions at a multidisciplinary meeting are fully realised when determining thresholds for admissions.

Absence management plans that were developed at the admissions stage of a young person's placement were revised on a regular basis following a risk assessment process. Individual risk assessments and safety plans were completed when deemed required by staff and management.

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

The centre had policies on supporting behaviour change, managing challenging behaviour, consequences and restrictive practices. There was evidence that staff used a positive approach in managing behaviour. In interview and through questionnaires staff named how positive behaviour was recognised and promoted and when negative consequences were applied. The inspectors were informed that young people were informed of their expected behaviours at the outset of their admission to the centre. This information was also contained in the young person's information booklet.

All staff had been trained in a recognised model of behaviour management with refresher training dates recorded on the centre's training needs analysis. Both young people had individual crisis support plans on file that included agreed physical interventions if warranted and only to be used as a last resort. The individual plans were regularly updated and in response to new behaviours. There had been no incident where the two young people in placement at the time of the inspection had been physically restrained. Through discussions at daily handovers, team meetings, supervision, reflective practice and individual placement plan meetings, staff discussed underlying causes of young people's behaviours. Young people were supported to manage their behaviour through life space interviews, keyworking and everyday staff interactions with the young people.

At the time of this inspection the centre was in the process of completing a thematic audit based on themes Three and Five of the National Standards for Children's Residential Centres, 2018 (HIQA) which included auditing the centre's approach to managing challenging behaviour. An action plan had been devised by the compliance officer for theme three only and timeframes had been set for the implementation of actions named in the action plan. Other mechanisms in place that assisted the centre in monitoring its approach to managing behaviour included specific risk assessments, safety plans, restrictive practices and daily risk assessments.

The centre's restrictive practices policy was connected to the centre's policies on behaviour management, safeguarding and the notification of significant events. A restrictive practices register was in place. The compliance officer had identified during their audit of the register that a restrictive practice was not included in the register and highlighted this with the centre manager. The inspectors found that staff

in interview and from the review of questionnaires displayed a good knowledge of what constituted a restrictive practice. Restrictive practices in the centre were deemed appropriate, risk assessments were completed, review dates had been recorded and involved social work consultation. Records relating to restrictive practices were stored on the young people's care files.

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

The inspectors found that young people and staff were supported to raise concerns and report incidents. Individual keyworkers were appointed to both young people whose responsibility was to ensure that the voices of the young people were represented at all stages of care planning processes and that they advocated for the young people. The voices of the young people were also heard at the weekly young people's meetings and at statutory care plan meetings. The inspectors found no evidence of any complaints made by any young person. One of the young people stated through questionnaire that they could make a complaint to any staff member with the second young person identifying a named staff member as the person they would speak to if they were unhappy about something. Information relating to complaints was detailed in the centre's information welcome booklet in addition to external support services available to them. In interview, one social worker was satisfied that the young person they were allocated to understood the complaints process. The second social worker identified that this piece of work was outstanding and that they will complete it. Complaints and whistleblowing were standing items at the team meetings. As reported under 3.1 all members of staff were not familiar with the whistleblowing policy. The inspectors recommend that the policy is refreshed in full at a team meeting. Feedback forms were in place for social workers and families to provide feedback and identify areas for improvement.

The centre's policy on the notification, management and review of incidents was last updated in August 2021. This was in response to actions identified by the Alternative Care Inspection and Monitoring Service (ACIMS) following inspections of other centres within the organisation earlier in 2021. Inspectors had collectively identified that the mechanisms for reviewing notifications of significant events (SEN's) required further clarity with respect to their purpose and function and how learning was disseminated to centre management and staff teams. The updated policy was found to comply with regulations and national policy and was connected to other relevant policies for example risk assessment, complaints, behaviour management and child protection. Both social workers confirmed in interview that they received

notifications of SEN's promptly and were satisfied with the quality and content of them. The inspectors review of the centre's SEN register verified this.

The centre's mechanisms for reviewing incidents included the centre manager reviewing all incidents with further discussions taking place during handovers, debriefings where deemed necessary and at team meetings. There was a mechanism for further in depth in-house significant event reviews to occur. There was evidence of the centre manager utilising this review mechanism. Externally, the role of the SEN team and regional significant event review groups (SERG) is now more defined with each having clear roles and responsibilities and they were connected. However, in terms of organisational learning there is a deficit in the possibility of such learning not being achieved due to SERG groups being in place regionally. The inspectors recommend that senior management considers potential learning from an organisational perspective.

Compliance with Regulation	
Regulation met /not met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.3** **Standard 3.2**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**None identified**

Actions required

- Senior management must ensure that all staff are provided with child protection training, satisfy themselves that all centre staff have a clear understanding of the various reporting procedures in place and that governance structures identify child protection concerns in a timely manner.
- Senior management must ensure that the level of risks identified from risk assessment processes and discussions at a multidisciplinary meeting are fully realised by when determining thresholds for admissions.

Regulation 5: Care Practice s and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

A sub-committee for 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 where deemed required. Policies that had been updated included complaints, admissions and notification of significant events. The child protection policy was found to comply with Children First, 2017. Deficits in safeguarding practices have been reported on under 3.1 of this report.

In interview, there was a mixed response in updated policies and procedures being identified to the inspectors. There was better demonstration of the staff team's knowledge of policies and the national standards through questionnaire. It was stated to the inspectors that policies and procedures were discussed periodically at team meetings and when the opportunity occurred. The regional manager must ensure that all working in the centre are familiar with the operational policies and procedures.

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.

It was evident to the inspectors that leadership, governance and management structures were in place in the centre. The centre manager, as the appointed person in charge for the day-to-day running of the centre was experienced and was reported by staff as being supportive, provided good leadership and was available to them. The centre manager was present in the centre Monday to Friday and attended handovers, team meetings, care reviews and was part of the on-call system. Oversight across centre records and young people's files was observed by the inspectors. Supervision was delegated between a senior member of staff and centre management.

From their review of a sample of staff supervision records and from interviews it was the inspectors' findings that supervision was a supportive piece of work for staff, was held in line with policy and that discussions relating to the young people and staff roles and responsibilities took place. Some improvement is required as it was found there was no evidence of oversight by the centre manager of other supervisor's work. For one staff member there had been a change of supervisors with no record on file indicating why and there was a deficit is some discussions being tracked in subsequent sessions.

There were clearly defined governance arrangements in place and staff interviewed were aware of the management structure and individual roles and responsibilities. Governance responsibilities included the centre manager completing weekly operational reports, HR reports and attending monthly management meetings. There was evidence of the centre manager being provided with monthly supervision by their line manager. Having reviewed a sample of operational visit reports the inspectors found that the line manager was providing the centre manager with good leadership and was clear of their expectations regarding the centre manager fulfilling their duties. The internal management structure was appropriate to the size and statement of purpose of the centre. The centre manager was supported by a deputy manager who had defined roles and management responsibilities. They acted up in the manager's absence. A written delegation of tasks was in place with a copy submitted to the inspectors.

The centre's policy on risk assessment and management detailed processes relating to risk identification. Centre management and staff demonstrated in interview a good understanding of the risk management framework. The inspectors found from the review of centre records and young people's files that from the time when the two current young people commenced their placement risks were identified and assessed with management plans developed to mitigate or reduce the levels of risk. There was evidence of safety plans developed when required. Centre and organisational risk registers were in place. Externally, improvement is required regarding the implementation of risk management procedures. As mentioned under 3.1 of this report deficits existed with respect to the pre-admissions risk assessment process whose responsibility rests with senior management.

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

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre's statement of purpose was found to have been in line with the requirements of the national standards. Services provided by the organisation and centre were clearly described. The statement was on display in the centre. An accessible format was available for young people, their families', social workers and staff. Information on the trauma and attachment informed model of care was reflected in the statement. A few staff had yet to be provided with training on the model. They had been provided with an information booklet and were encouraged by centre management to be familiar with it. Staff gave a good account of model of care in interview and through questionnaires. They also spoke positively of the benefits of the revised model. A date when the statement was scheduled to be reviewed was absent. The centre manager had completed their governance responsibility in auditing the statement. However, inspectors found from the review of the self-audit that the deficits highlighted above were not identified as all standards relating to 5.3.4 were deemed compliant.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Auditing and monitoring arrangements included internal and external processes for reviewing the quality, safety and continuity of care provided to the young people. Internal mechanisms included for example, team meetings, supervision, weekly operational reports and daily handovers. Team meetings were being held regularly and attendance was noted as good. The inspectors found that the team meeting minutes could be strengthened to include more detail as there was limited information recorded for some sections. Staff were provided with training at the induction stage of employment with further training provided through the organisations training awareness development programme. 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 appropriate fire safety were the identified types of training. Due to the Covid-19 pandemic fire training was being provided online. However, at this current time the organisation must explore onsite fire safety training that includes the safe use of firefighting equipment.

The centres audit system was based on the national standards and required input by the centre manager and the organisations compliance officer. Since the centre opened in May 2021 two in-house audits had been completed with one having been reviewed by the compliance officer and an action plan developed. In interview the centre manager's knowledge of the auditing system was vague. Due to the quantitative approach to completing the audit the inspectors could not determine how the criteria within the standards were deemed compliant. The inspectors recommend that the centre manager is provided with further guidance in completing audits.

It was evident that internal and external systems were in place to ensure that information relating to complaints, concerns and incidents were recorded, acted on, monitored and analysed. Individual registers were kept for complaints, incidents and concerns, all of which are part of team meeting agendas. The centre manager was aware of their responsibilities in updating the staff team of learning from SERG reviews at team meetings and daily handovers.

As the centre was operating four months at the time of this inspection an annual review of compliance had not been completed. The centres auditing system will capture the centres compliance with the centres objectives and improvements required.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.1** **Standard 5.2** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The regional manager must ensure that all working in the centre are familiar with the operational policies and procedures.

- The centre manager must demonstrate a greater oversight of the supervision process in the centre.
- The centre manager must ensure that all staff are provided with all mandatory training 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
3	Senior management must ensure that all staff are provided with child protection training, satisfy themselves that all centre staff have a clear understanding of the various reporting procedures in place and that governance structures identify child protection concerns in a timely manner.	With immediate effect. Any staff member who has not received full training will be scheduled to have this completed before the end of December 2021. Centre management in the interim will ensure that child protection and responsibilities to same are an agenda item at all team meetings.	The training team will ensure that all members of staff have been provided with Children First training, deficits will be flagged to centre management for completion within a reasonable timeframe. As part of a regional managers visit to the home, they will be following up on CAPA's and will ensure follow up is completed on any issues which required action. Also, regional management will check as part of their supervision that all matters relating to child protection are formally discussed
	Senior management must ensure that the level of risks identified from risk assessment processes and discussions at a multidisciplinary meeting are fully realised by when determining thresholds for admissions.	With immediate effect. As part of the governance committee all learnings are now brought to this forum and this informs processes going forward. There is now a robust system in place which incorporates our group impact risk assessments, the admissions policy will be	Due to organisational expansion the need for a dedicated referrals team has been identified, whose sole purpose will be to ensure that comprehensive assessments and action plans from multi-disciplinary meetings inform referral decisions going forward.

		updated to include internal transfers. This will be ratified at the governance committee on the 4.11.2021.	
5	The regional manager must ensure that all working in the centre are familiar with the operational policies and procedures.	With immediate effect. The regional manager and the home management team will conduct an audit to ensure that all team members have read and understood the operational policies and procedures. Furthermore, the regional manager will ensure that any deficits in knowledge will be addressed by the home management team via staff supervisions and team meetings.	In discussion with the training team the process via induction will ensure that all new staff have had the opportunity to read the policies and procedures and ask questions on same. This must be signed off by the training team before a new member of staff joins the team. For existing staff, the management team will continue to discuss operational policies and procedures via team meetings and supervision.
	The centre manager must demonstrate a greater oversight of the supervision process in the centre.	With immediate effect. Clear allocations will be specified in relation to which manager is supervising individual staff members. The home manager will ensure oversight of all supervisions monthly.	The home manager will meet with their management team monthly to review all supervisions conducted for pertinent handover pieces, key themes etc. If a manager is on annual leave and unable to carry out the supervision a clear record of a handover will be conducted between managers. The subcommittee for policies and procedures will review same in the supervision policy and submit to the

	The centre manager must ensure that all staff are provided with all mandatory training including onsite fire safety training.	With immediate effect. The home manager will link with the training team in relation to any deficits in training and ensure that a schedule of outstanding training is put in place. To be completed by mid-December 2021.	governance committee on the 26.11.2021. The organisation is currently reviewing their systems and are looking at a programme which will electronically alert to all training, not just mandatory training. In the interim, the training team will develop better forms of communication in relation to training with management teams. Home management will flag with the regional manager if there are outstanding deficits in training which are not being followed up on time.