An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 219

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Ashdale Care Ireland**
Registered Capacity:	**Two Young People**
Type of Inspection:	**Announced Inspection**
Date of inspection:	**2nd, 6th and 7th November**
Registration Status:	**Registered from 6th April 2023 to 6th April 2026**
Inspection Team:	**Lorna Wogan** **Linda McGuinness**
Date Report Issued:	**19th December 2023**

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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 and Regulation 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 6th April 2023. 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 6th April 2023 to the 6th April 2026.

The centre was registered as a dual occupancy service to provide medium term care for young people aged 13 to 17 years on admission. The residential programme was based around a researched based model named CARE (Children And Residential Experiences). The approach to care was also informed by trauma informed theories. The team had access to the organisations therapeutic support team. At the time of the inspection the centre were contracted to provide a bespoke single occupancy programme of care. There was one child 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
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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

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 28th November 2023. 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 7th December 2023. 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: 219 without attached conditions from the 6th April 2023 to the 6th April 2026 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 wellbeing and personal development.

This standard was found to be met in full. The centre had policies and procedures in place on placement planning and key working. There was an up-to-date care plan on file for the young person in placement. The initial care plan review was not undertaken within the first two months of placement, in line with the requirements of the regulations, however the inspectors were satisfied that weekly multi-disciplinary meetings continued to be scheduled for the young person following their admission therefore there were no deficits in planning and review processes. There was evidence of effective communication and collaborative work between the range of professionals involved to implement the care plan. The single occupancy arrangement was approved for a period of six months and was scheduled for review in January 2024. The care plan on file was comprehensive and child centred in its content. There was evidence on file that staff maintained their own record of the care plan review meeting to assist them to update the placement plan.

There was evidence of the young person's participation in the care and placement planning processes with their wishes, dreams and hopes for the future identified in key working sessions. The young person told the inspectors they felt their voice was heard and staff considered their views. There was a placement plan on file that was updated monthly and was aligned to the care plan. Action plans to guide key working and individual work were incorporated into the placement plan. Key workers were appointed and took responsibility in conjunction with their managers to ensure placement plans were updated. There was evidence on file that key working and individual work was completed monthly. Significant conversations with the young person were also recorded on the care record. This work was of a high standard with a good focus on the young person's safety, and their emotional and psychological wellbeing. Placement plans were discussed at team meetings where staff had the opportunity to have input. Additionally, individual work, key working and placement

planning were evidenced as discussed in the staff supervision process. Weekly planners were developed that evidenced structure, routine and consistency which were prominent features of care for the young person.

The young person had access to a number of external professionals who were known to them for many years such as their allocated social worker and their Guardian ad Litem. They also had information about the national advocacy group for young people in care (EPIC) and had met with the regional advocate from EPIC. There was evidence of open communication and good collaboration with external professionals. This was confirmed with the allocated social worker and the Guardian ad Litem. They commended the centre manager and the team for the care and support they provided to the young person to date. Additionally, there were systems in place within the team to ensure effective communication and planning such as the daily logs, handover meetings and regular team meetings. A handover meeting attended by one of the inspectors was child-focused and reflective and covered all key aspects of care and planning.

There was a robust admission process in place that identified the young person's needs and the risks associated with their presentation. Inspectors found that staff were provided with relevant information to support the young person. There were meetings with the team to ensure consistency of care on admission. Information sharing workshops were facilitated by an external specialist service engaged with the young person and also with the centre manager from a previous placement who knew the young person well.

The young person had access to the required specialist supports at the time of the inspection. There was evidence that guidance and advice from specialists was relayed to the team and incorporated into the care approach and programme of care. There were weekly multi-disciplinary meetings to review and evaluate interventions and their effectiveness that included members of the services therapeutic team. Records of all planning meetings were maintained on file. The staff team promoted and supported family contact in line with the care plan and were attuned to the emotional support the young person required to maintain family connections.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 2.2**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- None identified

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

This standard was found to be met in full. The inspectors found the centre manager and staff had a clear understanding of the young person's behaviour and how to support them. There were a range of policies and procedures in place to guide and support behaviour that challenges such as supporting behaviour change, managing challenging behaviour and consequences. The care approach was both evidence-based and rights based with clear practice guidelines. The young person had completed key working on the rights of children. There was evidence of consultation with them about all aspects of their behaviour and how the staff would support them to meet agreed expectations. The policy in relation to behaviour management was aligned to and guided by the centre's model of care. The inspectors' found staff were well trained in the behaviour management approach through policy induction, behaviour management training, review of the behaviour management approach in supervision and guidance from specialist services. Refresher training in the crisis intervention behaviour management approach was undertaken every six months and the recently appointed centre manager was scheduled to undertake their refresher training at the time of the inspection.

There was evidence the staff followed a defined plan to promote positive behaviour and manage behaviour that challenged in a manner that promoted teaching and learning. The young person's positive behaviour support plan identified numerous interventions that supported relationships and attachments, which identified clear

and consistent expectations and were linked to key aspects of the young person's needs and presentation. This plan was developed in conjunction with the placement plan, the individual crisis support plan (ICSP) and the individual risk management plan (IRMP). Through the multi-disciplinary meetings staff were supported to understand and identify the underlying causes of behaviour that challenges and the interventions to assist and respond. Staff were provided with sufficient information to ensure they had an awareness of how abuse and neglect could impact on behaviour. Additionally, the therapeutic care approach was reinforced with staff through their supervision with the centre manager.

Consequences or sanctions were not a regular feature of the young person's care. There was a focus on role modelling, teaching, showing, advising, nurturing and explaining expectations and boundaries. There was evidence that staff undertook individual work to address behaviours following incidents, engaged the young person in roles plays, mediation, developed contracts with them and undertook life space interviews where appropriate. The young person told the inspectors that the staff helped them with difficulties they experienced.

The ICSPs to support crisis behaviour were comprehensive and reviewed monthly. There was a detailed risk assessment completed to address the risk of unauthorised absences in the IRMP and there was evidence these plans were reviewed and updated as required on a monthly basis. The IRMP evidenced an assessment of all the known and potential risks and were completed in line with the centre's risk management framework. The current behaviour management plans were stored in an active folder thus were accessible to staff and were referenced as required during the handover meeting. Safety plans were developed to support safe care routines. New activities were subject to dynamic risk assessments and signed off by the centre manager and on the care file. Staff interviewed were familiar with the centre's behaviour management approach and the behaviour management plans in place.

There were systems in place to track significant events, incidents, restraint interventions, child protection concerns, consequences, individual work and key working through the monthly evaluation forms, and through the centre registers and daily logs. The inspectors found these logs were accurate and up to date. There was consent on file from the social worker to implement a specific restraint intervention where required. One incident of physical restraint was recorded on file and was found to be appropriately reported and reviewed. There were no incidents of the young person missing from care to date. Debriefing was completed with staff

following incidents and there was a structured template for undertaking this process with learning outcomes identified.

Significant event reports were written to a high professional standard with evidence of implementation of safety plans, care approach and de-escalation techniques. These incidents were subject to an in-house review process with learning outcomes identified. The organisation had a system in place to undertake external reviews of high-risk incidents however none of the incidents to date for the young person currently in placement met the threshold for a review by external managers. Significant event reports were found to be forwarded to the relevant parties in a timely manner.

There was a range of systems in place to assist the young person to develop an understanding of behaviour that challenges and behaviour that is respectful of the rights of others. The IRMP gave consideration to the impact of the management plan on the young person's rights and where rights were impinged this was recorded as a restrictive practice. The centre had a policy on the use of restrictive practices and the identified restrictive practices on the care records were subject to tracking, assessment, and review. External professionals were consulted in the implementation of restrictive practices and staff interviewed were knowledgeable about the current restrictive practices in place and the rationale for them. Additionally, restrictive practices were explained to the young person where they were implemented.

Compliance audits are undertaken twice per year by an external auditor. To date one external audit was completed in August 2023. There was evidence that identified actions required were addressed and audits were discussed at monthly management support meetings. Additionally, the regional manager completed reports on their oversight of centre practices. There were audits completed on the behaviour support plans. There was robust oversight of practice by the regional manager with regular visits to the centre and supervision of the centre manager.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 3.2**

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

Actions required

- None identified.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

Leadership was evidenced at all levels within the organisation, from the social care leader to the centre manager, to the regional manager and the directors of care, governance, and quality. There were clear lines of authority in the organisation and staff interviewed were familiar with the various levels of management and their individual roles within the wider organisation. Management support meetings were scheduled monthly and evidenced oversight of practice, leadership and accountability.

The centre was currently contracted by Tusla's national private placement team (NPPT) to provide a single occupancy bespoke placement for a young person for a specified period. This single occupancy arrangement will be subject to review by the NPPT in January 2024.

The current person in charge was recently appointed in an acting capacity. The person in charge was sufficiently experienced and skilled to undertake the role. At the time of the inspection, the centre manager was undertaking additional studies to achieve the required qualification for the post and was due to complete the course in June 2024. Additional supports and supervision were in place to support the centre manager in their role while undertaking the role in an acting capacity. Staff interviewed stated the internal managers were supportive and provided strong leadership to the team. Staff supervision records completed by the centre manager

were found to be supportive, reflective, action focused with an emphasis on skills development.

Policies and procedures were developed, reviewed and updated as required taking account of national standards, regulations and best practice guidelines. The policies were clear and comprehensive. Staff confirmed they signed off on policies they had read and reviewed during their probation period. There was evidence that key policies were also reviewed with staff in supervision and at team meetings. Staff interviewed were familiar with the centre policies and procedures.

There was a risk management framework in place and pro forma to undertake risk assessments. There was a centre risk register and individual risk management plans in place. All relevant risks were identified, measured on risk matrix with control measures identified. Time periods for review of risk assessments were identified and evidenced as reviewed in team meetings.

Since the point of initial registration, the deputy manager and one of the social care leaders resigned from their post therefore the current internal management structure comprised of the centre manager and one social care leader. The directors stated that due to the single occupancy nature of the placement the deputy manager post will not be replaced at this time. However, the inspectors recommend the appointment of an additional social care leader post in the centre to strengthen the internal management support for staff. There was six newly recruited staff members since May 2023 with two additional staff members on-boarding in the coming weeks therefore the team require social care leaders to guide, supervise and support staff on duty.

At the time of the inspection the centre manager was training the social care leader to undertake some additional management tasks. In the interim the regional manager confirmed to the inspectors they would provide management support to the centre in circumstances were the manager was absent from the centre. There was a written record maintained as required of all management tasks that were delegated to the social care leader.

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 operations must ensure the internal management structure is appropriate to the size and purpose and function of the centre.

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 an organisational policy on the recruitment and retention of staff. There were systems in place to evidence workforce planning. Weekly workforce meetings were undertaken whereby the centre manager relayed staffing requirements to the human resource managers.

The staff retention policy outlined that staff retention was the cornerstone of implementing the trauma and attachment informed model of care. However, there was a significant turnover of staff since the initial registration with only four members of the original team remaining in the centre which, if this pattern were to continue, the centre would struggle to implement the model of care. Since the admission of the current young person the inspectors found some evidence of team stabilisation. There were systems in place to identify the reasons why staff resigned from their post and staff members were offered an opportunity to complete an exit interview. Overall, staff did not take up this offer and only one exit interview was undertaken to date. The directors within the organisation must consider additional ways to promote more active engagement of staff in the exit interview process.

Throughout the course of the inspection the inspectors identified several factors that impacted on staff retention. The staff retention policy outlined that the retention strategy would be subject to a review on a half year basis. The directors informed the

inspectors they had recently sought staff views on working within the organisation. The director of care informed the inspectors they had incorporated the issues that impacted on staff retention in this centre into the retention review process. A report on the findings of the staff consultation process and how it would inform retention strategies within the organisation was not finalised at the time of the inspection.

The centre's statement of purpose outlined that the centre had between eight and ten staff members dependant on the number and needs of the young people in the centre. At the time of the inspection there were six whole time equivalent (WTE) posts, inclusive of four part-time staff, and two staff due to commence employment at the end of November 2023. When these positions are filled the team will have the minimum required staff numbers in line with the ACIMS regulatory notice on staffing numbers issued June 2023. The director of care must notify the inspectors in writing when the additional staff members commence employment and the minimum staffing numbers have been secured.

All staff had a recognised qualification in social care or a relevant or related qualification in compliance with the aforementioned notice. While there had been a high turnover of staff since the initial registration of the service in April 2023 there was evidence that the team had stabilised and were becoming more cohesive and confident in their practice. The inspectors were informed there were plans in place to undertake a team building day. The supervision records evidenced that key policies and care approaches were reviewed to ensure each staff member was familiar with their roles and responsibilities. Interviews with staff, observations of staff in centre, and a review of supervision records evidenced a motivated and overall positive team.

Following a review of staffing rosters, the inspectors found that the 2:1 staffing requirement was adhered to at all times day and night despite staffing deficits. There was evidence that a number of relief staff and staff from other centres within the organisation completed shifts in the centre combined with core staff undertaking additional shifts over the summer period. There was evidence the manager made every effort to ensure more experienced staff were rostered with newly recruited staff.

The inspectors reviewed the personnel files and found some discrepancies in information on file in particular around staff commencement dates. These discrepancies were clarified at the time of writing this report. However, the inspectors advise that the employment related dates on the personnel files are accurate.

The centre had an on-call policy. There were clear guidelines for staff in relation to contacting the on-call support. Centre managers, deputy managers, regional managers and senior practitioners provided the on-call service. Records were maintained of all on-call activity. Staff were aware who was on call after hours and at weekends. Staff confirmed it was a reliable and effective support.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The director of care must notify the inspectors in writing when the additional staff members commence employment and the required staffing numbers have been secured.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	N/A		
3	N/A		
5	The director of operations must ensure the internal management structure is appropriate to the size and purpose and function of the centre.	30.01.24 - Home manager will have an additional identified Social Care Leader in the home to support the current management structure.	Going forward, the number of social care leaders in homes will be tracked at work force planning. This will ensure there are adequate management support in all homes.
6	The director of care must notify the inspectors in writing when the additional staff members commence employment and the required staffing numbers have been secured.	Two whole time equivalent staff members commenced in the centre on 01.12.23.	Staffing levels will continue to be monitored on weekly workforce planning meetings and focus given to any areas of need. Once the retention strategy review has been finalised, identified actions will be rolled out across the organisation in order to improve overall retention within the organisation.