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: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Three Young People**
Type of Inspection:	**Announced**
Date of inspection:	**05th, 06th & 10th July 2023**
Registration Status:	**Registered 31st January 2021 to the 31st January 2024**
Inspection Team:	**Ciara Nangle** **Janice Ryan**
Date Report Issued:	**27th September 2023**

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 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 31st January 2006. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from 31st January 2021 to the 31st 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 models; developmentally focused, competence centred, family involved, trauma informed, relationship based and ecologically orientated. 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	Standard 3.2 only
6: Responsive Workforce	Standard 6.1 only

This inspection activity was conducted as a result of an escalation sent by the National Private Placement Team to ACIMS in relation to the management of the complex dynamic and behaviours that were present between young people living in the centre. The focus of this inspection was to determine whether appropriate risk assessments and safety plans were in place and that appropriate actions were being implemented to support staff in managing the challenging behaviours in an effective way.

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 on the 24th August 2023 and to the relevant social work departments on the same date. 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 September 2023. The CAPA was reviewed and all non-compliance with regulatory matters identified in the report have now been addressed to the satisfaction of the Alternative Care Inspection and Monitoring Service and the relevant regulations now deemed to be met.

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 January 2021 to 31st January 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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.

The centre had policies and procedures in place to support the positive management of behaviour that challenged. Inspectors noted some evidence of policies being shared with the team through written documents which staff were required to sign to confirm having read, however there was little evidence of policies and procedures being reviewed at team meetings or in any other forums to ensure staffs understanding and knowledge around policies and procedures and this requires improvement.

The centre operated under a model of care, and the organisation's policies were aligned to this model. The centre had a recognised framework of behaviour management in place and staff were trained in this. However, not all staff in the centre were trained in the organisation's model of care. From the young people's records reviewed as part of this inspection, there was a lack of evidence of the implementation of the model of care through care practices. At times, inspectors noted that practices within the centre e.g. sanctions, were not aligned to the model of care. This was identified as part of an internal review of documents and supports were identified.

When sanctions were put in place within the centre, at times they were assessed by inspectors to be punitive/restrictive practices and were not appropriate to the young people's age or stage of development or aligned to the care model. There was no evidence of centre management oversight of these sanctions within the records in the centre and where inspectors noted it being discussed by external management, there was no evidence of follow up or a change in practice. All sanctions utilised within the centre require review to ensure they are aligned to the model of care and are appropriate for the age profile and needs of the young people in the centre.

As part of this inspection a sample of Significant Event Notifications (SEN) were reviewed to ascertain the centre's approach to the management of behaviour that

challenged. Within these documents inspectors found that they lacked details of the approaches taken by the staff team to manage the behaviour, timelines were not always included and the details of the behaviours of concern were limited often citing "due to level of violence" with little detail included to explain the behaviour. This made it difficult to evidence the decision making behind the team's care practices. The records did not demonstrate that the practices within the centre were fully aligned to the model of care or the framework of behaviour management that the staff were trained in. At times, just one significant event notification was completed despite it referencing a number of events spanning across a day and thus the number of significant events within the centre was not accurately recorded. Improvement in the recording of significant event notifications is required to ensure they are reflective of the practices in the centre and are aligned to the framework for the management of behaviour being utilised.

From the information available within the SEN records reviewed, inspectors found that the centre was over utilising physical interventions as a mechanism to manage behaviour that challenged. At times, it appeared from the sample of records reviewed that physical intervention was the first response when a young person was presenting with behaviour that challenged and at times these physical interventions were 'non-routine' and outside of those prescribed in the model of behaviour management. Inspectors identified that staff had engaged in 'non routine' physical interventions on a number of occasions, and at times these were unsafe practices. Inspectors found little evidence from external management in addressing these unsafe practices to ensure that the young people were being provided with safe care. While staff and management indicated in interview that physical intervention was only used as the last resort this was not reflected in the records available to inspectors.

Additionally, inspectors did not see evidence of regular debriefs with staff occurring following incidents and did not see records of issues being addressed where practice was unsafe as mentioned above, was not in line with the young people's Individual Crisis Support Plans or aligned to the behaviour management framework. While Significant Event Review Group (SERG) meetings were occurring, it was not clear to inspectors how actions arising from these were tracked, how the information was fed back to the team or what changes to the practices within the centre were being recommended. The details contained within the minutes of these meetings was often limited so it was difficult to ascertain what was discussed and if patterns and trends, or staff practices within the centre was discussed or analysed and if feedback was provided to the team.

Inspectors noted that additional training had been provided to the team in relation to helping them to develop an understanding of the underlying reasons for the young people's behaviours. However, inspectors did not see evidence of on-going discussion with staff, through supervision or in team meetings to support this understanding and support the team in managing the complex behaviours within the centre. Both young people had an up-to-date Individual Crisis Support Plan, which included detailed information in relation to the young people's behaviours and what may lead to an escalation. They had placement plans, and documents detailing their morning and evening routines. However, the records of discussions in relation to these documents within team meetings was minimal. Additionally, staff did not sign off the documents to evidence having read it and as such inspectors could not determine to what level staff had an awareness of these documents to ensure their practices were aligned to them.

Age-appropriate key working was being completed with the young people and was aligned to their placement plans and focussed on supporting them to understand behaviours. These were child friendly, used visual aids and their goals were mapped with the young people on a regular basis. Life Space Interviews were attempted with the young people following some of the SENs to support them following the incident, however they did not always engage. When they did occur, inspectors noted a theme within the young people's voices of feeling unsafe when new staff were working within the centre. The impact of new staff in the centre was also something that was regularly recorded within the managers comments following SENs. However, inspectors did not see evidence of actions being taken to address this or mitigate the impact of it on the young people.

Inspectors could not easily identify how the approach to the management of behaviour within the centre was being monitored. Evidence of management oversight on records was limited and when issues with practice arose it was not clear to inspectors how this was followed up or addressed with the staff team and how changes to practice would be tracked. Additionally, it was difficult to determine what level of oversight was in place from personnel external to the centre (for example, therapeutic team) as it was reported that they had input into team meetings however minutes of team meetings for the previous three months were unavailable as they could not be located on the day of inspection. Additionally, the centre advised that the organisation's personnel were not required to sign into the visitor's log. This requires immediate improvement as it presents as a safeguarding issue.

Inspectors reviewed an Audit completed in June 2023 by the Quality Assurance Department under Theme 3 of the National Standards for Children's Residential Centres, 2018 (HIQA). Within this audit, some of the issues identified by inspectors were also identified. However, the action plan generated as part of this audit did not clearly detail what specific action would be taken to address the deficit and in some instances the timelines included were not appropriate and did not allow enough time for the action to be implemented. It was also unclear to inspectors how this action plan would be tracked to completion and what the oversight of this action plan was.

Restrictive practices were in place within the centre however staff were not clear on what constituted a restrictive practice. Regarding the restrictive practices that were in place, it was not evident to inspectors how these were reviewed to ensure that they were only being kept in place for the shortest time possible in line with the National Standards for Children's Residential Centres, 2018 (HIQA). The centre operated alarms on the young people's bedroom doors and a new guidance around the use of this had been introduced within the organisation following the identification of deficits within another centre during an inspection completed by the Alternative Care Inspection and Monitoring Service (ACIMS). However, staff were not clear on this new procedure and practice in the centre did not reflect the new guidance. As such only one staff was alerted to the buzzer and did not wake the second staff member if a young person was awake, additionally the details of young people waking during the night was only recorded in the buzzer log, and not reflected in the young person's logs. This presents as a safeguarding issue and this requires improvement to ensure safe care practices.

Compliance with Regulation	
Regulation met	**Regulation 16**
Regulation not met	**Regulation 5**

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

Actions required:

- The registered provider must ensure that the staff team are regularly updated on the organisations policies and procedures and staff are provided with opportunities to discuss these to ensure thorough understanding.

- The centre manager must ensure that significant event records are detailed and include all interventions used by staff in managing an incident in line with the behaviour management framework.
- The registered provider must review all physical restraints within the centre from April 2023-July2023, to ascertain that they were in line with policy, conducted appropriately and used to support the children to manager their behaviours
- The register provider must review and identify the number of non-routine physical interventions that have conducted, the reason for these, their necessity and identify if any physical intervention was used to enforce compliance by the young people.
- The registered provider must ensure that any learnings identified within these reviews is shared with staff, and develop a mechanism to monitor any changes to practice implemented as a result
- The register provide must ensure that all sanctions and physical interventions are tracked and monitored within the centre while the complex dynamic and behaviours of the young people remain.
- The registered provider must ensure that minutes maintained of Significant Event Review Group (SERG) meetings are detailed and record details of discussions and actions generated.
- The registered provider must ensure there is a mechanism for the tracking of actions arising from SERG meetings to ensure their completion.
- The centre manager must ensure that any learning identified with SERG meetings is shared with the staff team to support best practice within the centre
- The centre manager must ensure that identified issues in staff practice is addressed and recorded and that any required changes to practice are shared with the team when appropriate and tracked for implementation.
- The centre manager must ensure that all visitors to the centre are recorded in the visitor's log.
- The centre manager must ensure that the staff team are retrained in the organisations restrictive practice policy to ensure they understand this.
- The registered provide must review the restrictive practices currently in place and ensure they are identified correctly and the frequency for review is aligned to the National Standards for Children's Residential Centres, HIQA (2018)
- The registered provider must ensure that the new procedures in relation to the use of the buzzer system is implemented within the centre to ensure safe care practices.

- The registered provider must ensure that action plans arising from Themed Audits include detail of actions to be taken and have appropriate time frames.
- The register provider must ensure that there is a mechanism in place for the tracking of these actions plans and those with responsibility for same are clear of their role in this regard.
- The centre manager must ensure that a record of all team meetings is maintained and that these includes details of discussions that occur.

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.

Workforce planning for the centre was completed through the centre manager and regional manager. The regional manager attended a weekly meeting with the Human Resources department and advised of the staffing needs within the centre. Within the weekly meetings with the Head of Care, inspectors also saw evidence of some workforce issues being discussed. However, this was in the context of the impact on operations within the centre and management advised that generally work force wouldn't be discussed within these weekly meetings.

At the time of the inspection the centre was operating with six whole time equivalent (WTE) staff members. In the six months prior to the inspection there had been nine resignations, two of which were in the month prior to this inspection. Additionally at the time of inspection the centre manager, who had been in post for 6 months had resigned and was returning to the deputy manager post which was vacant. The centre operated with two sleep over staff and an additional day support. The centre was due to have two new members of the team and one relief staff member start on the week the inspection activity concluded.

Prior to June 2023, the centre had been operating with the required number of staff however was unable to full its rota with the core staff team and relief staff. As such, the centre was relying of staffing from other centres to regularly complete shifts within the centre. Inspectors sampled 6 weeks of rosters spanning over a three-month period from April to June 2023. During this period, inspectors ascertained that at least thirty five different members of staff worked in the centre during that period of time. This was in the context of the therapeutic team and external support services advising that the inconsistent staffing was negatively impacting on the young people given their individual needs. This was in addition to the manager noting that new staff members had an impact on significant events occurring and the young people voicing that they did not feel safe with new staff. However, outside of recruiting new staff, inspectors could not ascertain what other actions the organisation had taken to try to minimise the impact of the staffing issue on the young people.

The inconsistency in the regularity of staffing within the centre was also impacting on the core team that was available. Inspectors noted in records that the staff team were feeling the negative impact of managing the complex dynamic and behaviours within the centre, however inspectors did not see additional supports being offered. Supervision of staff was not occurring in line with the organisations policy and post crisis reviews and debriefs were minimal. Consequently, staff practice was not being reviewed or challenged through these forums and the staff were not being supported through them either. This requires immediate improvement to ensure safe care for the young people and support for the staff.

In interview the staff advised that there was external counselling supports available to them and that both the centre manager and regional manager was available to them should they need it. Staff were not confident in the organisational structure outside of their immediate management team but knew where to get this information should they require it.

They advised that they are supported to engage in continuous professional development and that training in relation to the young people's presenting needs is available should they request it. However, given the complexities of the behaviours of the two young people, combined with an inconsistent staff team, the inspectors found that this was directly impacting the team which they had reported to management. Inspectors could not see evidence of any measures taken by the organisation to provide additional support to the team in light of these challenging circumstances to support staff retention to ensure consistency for the young people in the centre.

The centre had a policy in place for on-call. From interviews and records reviewed this policy was effective in its implementation and was being used appropriately by the team.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**None identified**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The registered provider must ensure that supervision of staff, debriefs and post crisis reviews occur in line with the organisations policy and the National Standards for Children's Residential Centres, HIQA (2018) to ensure staff are supported and practice issues are addressed as required.
- The registered provider must ensure that all efforts are made to provide consistency in the staffing within the centre in line with the best interests of the young people and that in the absence of the core team being able to fulfil the rosters that a plan is developed to minimise the number of different staff working within the centre.
- The register provider must ensure that the centre has sufficient and appropriate staffing and management personnel to comply with Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 7: Staffing

4. CAPA

Theme & standard	Action	Corrective Action with Time Scales	Preventive Strategies to ensure issues do not arise again with time scales
3	The registered provider must ensure that the staff team are regularly updated on the organisations policies and procedures and staff are provided with opportunities to discuss these to ensure thorough understanding.	Policies and procedures have been reviewed with staff team and sign off completed and in supervision folders.	Home management will review a number of policies as part of a set agenda at team meetings and supervisions. Home management will ensure all policies have been signed off as being read by all staff and will satisfy themselves that they are fully understood via supervision and monitoring staff practice. Compliance manager will complete audits in the home and ensure that all policies have been read and understood by staff through monitoring of paperwork [sign off] and asking staff details of specific policies and observing practice in the home.
	The centre manager must ensure that significant event records are detailed and include all interventions used by staff	With immediate effect, newly appointed home manager is reviewing all SENS to ensure all records are detailed and include interventions used by staff in managing an incident in line with the	At the next team meeting 08.09.23, Home management will complete a piece of work with the team and review the SEN reporting requirements and information that must be contained within. Where additional training is required for any staff, this will

	in managing an incident in line with the behaviour management framework.	behaviour support management framework. SENs are being reviewed alongside the SEN team to ensure full details of supports are recorded in the body of the document.	be requested and provided via the training department. Home management will complete reviews of all SENS and provide feedback as part of their development that will ensure they are meeting the required standard. SEN team will review SENS for the home to ensure adequate information is contained within, any recommendations will be fed back to home management for address. Compliance manager when completing audits will review the quality of SENS to ensure all required information is contained within. SEN are developing a guidance to be issued out to all homes on 'how to complete a SEN' by 30.09.23
	The registered provider must review all physical restraints within the centre from April 2023-July2023, to ascertain that they were in line with policy, conducted appropriately and used to	25.07.23 a review was completed on all physical restraints within the centre from April 2023-July2023, to ascertain that they were in line with policy, conducted appropriately and used to support the children to manager their behaviours. This report along with	SEN review process was reviewed and was fully implemented on 01.08.23; this process allows for improved monitoring of trends and use of physical interventions in real time and identify where there is an escalation of incidents/physical interventions which will trigger a SERG review. Any actions identified at SERG will be monitored and tracked by a member of the SEN team to ensure they are implemented.

	support the children to manager their behaviours	action plan was submitted to Registration and Inspection 28.07.23	
	The register provider must review and identify the number of non-routine physical interventions that have conducted, the reason for these, their necessity and identify if any physical intervention was used to enforce compliance by the young people.	25.07.23 a review was completed to identify the number of non-routine physical interventions the reason for these, their necessity and identify if any physical intervention was used to enforce compliance by the young people. This report along with action plan was submitted to Registration and Inspection 28.07.23 27.09.23 a bespoke TCI training will be completed for staff.	SEN process was reviewed and was fully implemented on 01.08.23; as part of this process all non-routine restrictive practices are reviewed by a TCI instructor; this is review is completed at SERG meeting to discuss, identify learnings and develop an associated action plan. Actions identified are monitor and tracked by a member of the SEN team to ensure they are implemented. The home has two TCI instructors on their team who will also provide support to management on the review of physical interventions.
	The registered provider must ensure that any learnings identified within these reviews is shared with staff and develop a mechanism to monitor	A new manager has been appointed to the home. Learnings from the internal review have been reviewed with management. Management are scheduled to review the learnings with the team at next team meeting 08.09.23.	A therapeutic support plan has been developed by Snr Behaviour Psychologist that incorporates Positive behaviours support, this will be reviewed with the team at a minimum every four weeks.

	any changes to practice implemented as a result.		
	The register provide must ensure that all sanctions and physical interventions are tracked and monitored within the centre while the complex dynamic and behaviours of the young people remain.	A new home manager in place as of 14.08.2023 and is reviewing all sanctions and interventions used in the home to ensure they are in line with best practice and principles of CARE. As part of the therapeutic plan, physical interventions and sanctions are reviewed by management and a member of the therapeutic team and TCI instructor.	As part of the SEN review process, sanctions and physical interventions are reviewed to ensure they are proportionate and in line with model of CARE. Where an SERG is held, consequences will be reviewed as part of this process. Regional management when in the home reviews the restrictive practices in the home. As part of the compliance managers role, they will complete audits that will review the use of physical interventions and sanctions in the home.
	The registered provider must ensure that minutes maintained of Significant Event Review Group (SERG) meetings are detailed and record details of discussions and actions generated.	With immediate effect, minutes of the SERG meeting will contain more details of discussion and associated actions agreed.	A member of the SEN team is responsible for the scheduling and minute taking of SERGs, where actions are agreed, a member of the SEN team will follow up with the home to ensure all allocated actions are completed within the specified timeframe.

	The registered provider must ensure there is a mechanism for the tracking of actions arising from SERG meetings to ensure their completion.	With immediate effect, A member of the SEN team will maintain all action plans from SERGS. They will follow up with home management to ensure all actions agreed have been closed out.	Home manager is responsible to ensure any actions arising out of SERG are completed within specified timeframe. A member of the SEN team will liaise with home management to keep a track of identified actions and ensure progress is being made to get them closed out. Where progress has not been made this will be escalated for review by Regional Manager. As part of the compliance managers role, they will complete audits in the home and will satisfy themselves that identified actions from SERG have been actioned.
	The centre manager must ensure that any learning identified with SERG meetings is shared with the staff team to support best practice within the centre.	With immediate effect, where a SERG review meeting is held, all learnings will be shared with the team via handover and team meetings.	Regional managers will highlight to all members of management, the importance and requirement to share learnings with their teams from SERG. All home managers will be requested to evidence learnings have been shared via minutes on team meeting, hand overs and supervision with their teams. Compliance manager will satisfy themselves that this process is being following as part of the auditing process.

	The centre manager must ensure that identified issues in staff practice is addressed and recorded and that any required changes to practice are shared with the team when appropriate and tracked for implementation.	14.08.23 A new home manager was appointed to the home and received a full brief on areas that require support and attention. Increased supervision [3 weekly] was completed with all staff in the home from [10.07.23] to present. Reflection on the CARE model principals and sanctions was completed at team meeting [22.08.2023 and 8.09.2023]. Training on positive behaviour support is due to take place 27.09.23 with the new manager and team. On going review and support from a member of TST will continue to ensure practices are aligned to training. Bespoke TCI training has been scheduled for 27.09.23 A full review of ICSP and practice was completed with Regional Manager at team meeting 22.08.2023. Home manager will ensure all recommendations from therapeutic	All staff receive mandatory training as part of induction and receive ongoing refresher training in line with recommended timeframes. Home manager will ensure that all staff are participating in practice in line with support plans. Ongoing training will be provided by a member of Therapeutic support team focusing on PBSP and review on practice in line with principles of CARE. Where specific training is required based on the presenting needs of the young person residing in the home, this will be provided. SEN team monitor SENs to ensure they contain appropriate information accurately and reflect good practice. Where recommendations are made, SEN team follow up to ensure actions are closed out. Regional management as part of home visits will observe practice in the home to satisfy themselves that it is in line with the young persons support plans. Compliance manager will complete audits in the home and ensure all recommendations are being practiced by staff.

		support team are implemented by all staff. Home manager will provide guidance, supervision and role model best practice with the team.	
	The centre manager must ensure that all visitors to the centre are recorded in the visitor's log.	With immediate effect, Home management have verbally communicated to the team that all visitors to the home are required to sign in the visitors log. This will be reiterated at team meeting 8.09.2023.	24.08.23 Director of Quality and Governance issued communication to all personnel in Ashdale Care to inform them all visitors to the homes are required under policy to sign in on the visitors book when visiting homes. Regional managers will revisit this at the next management meeting 28.09.23 and request that all managers bring this to their next team meeting and put on daily hand over to ensure all staff are fully briefed on the policy. Compliance manager will satisfy themselves that this policy is being followed when completing audits in homes.
	The centre manager must ensure that the staff team are retrained in the organisations restrictive	The home manager completed a full review of the restrictive practice policy with the team 13.07.2023 at team	Director of Care and Director of Therapeutic Support Services are in the process of reviewing the policy and procedure on restrictive practices. This will be completed by 30.11.23

	practice policy to ensure they understand this.	meeting and will re-visit this again at team meeting scheduled for 27.09.2023	Once complete, this will be communicated to management and staff teams.
	The registered provide must review the restrictive practices currently in place and ensure they are identified correctly and the frequency for review is aligned to the National Standards for Children's Residential Centres, HIQA (2018)	With immediate effect, the new home manager has put the review of restrictive practice as a standing agenda on team meetings. Home management will ensure that any restrictive practices implemented in the home are reviewed in line with policy and this will be noted in the restrictive practice register. Home management will ensure any restrictive practice is age and stage appropriate and utilised for the shortest time possible in line with policy. Home management will inform social work department on the use or need for restrictive practices.	Director of Care and Director of Therapeutic Support Services are completing a full review of restrictive practices policy and procedure which will incorporate the monitoring and restrictive practice reduction plans in line to the National Standards for Children's Residential Centres, HIQA (2018) Home management will complete a review of all restrictive practices bi-weekly. Compliance manager will ensure all restrictive practice reviews are completed in line with policy.
	The registered provider must ensure that the new procedures in relation to	A new alarm system was fitted in the home (16.08.2023) in both staff bedrooms.	A new alarm system is being rolled out across the organisation, this system will now have an alarm

	the use of the buzzer system is implemented within the centre to ensure safe care practices.	Home management have reviewed the system with all staff via handover. Home management will review the policy and procedure on bedroom alarms at next team meeting 08.09.23	panel in both staff bedrooms, once the alarm is activated it will sound in both areas. All members of management and staff will receive demonstration on how to use the alarm once the alarm is fitted. A visual step by step guide has also been provided to the homes. Policy and procedure for the updated system will be sent out once all alarms have been fitted [30.09.23] A log book will be maintained whenever the alarm is activated, a record will also be kept on the young persons log book as per existing policy. Home management will complete daily checks to ensure the policy is being followed at all times.
	The registered provider must ensure that action plans arising from Themed Audits include detail of actions to be taken and have appropriate time frames.	With immediate effect, compliance manager will include detail of actions to be taken following completion of an audit. Compliance Manager will review timeframes set out to allow enough time for action to be completed.	Compliance manager along with Director of Quality and Governance have reviewed compliance action plans and timelines for actions in each theme to provide enhanced details of actions required along with appropriate timeframes. This will be rolled out throughout the organisation with immediate effect.
	The register provider must ensure that there is a	Home manager is responsible for ensuring actions are closed out and is	Compliance manager tracks closing out of actions. With immediate effect, Compliance Manager will

	mechanism in place for the tracking of these actions plans and those with responsibility for same are clear of their role in this regard.	required to update and upload specific documents to the auditing system to reflect actions are complete. Where actions are incomplete, this alerts the Compliance manager who then reports the overdue action Regional Management for review.	request evidence of actions are uploaded onto the system as a means to provide assurance that actions are complete. As part of the follow up audit Compliance Manager will check that actions from previous audit were complete.
	The centre manager must ensure that a record of all team meetings is maintained and that these includes details of discussions that occur.	With immediate effect, newly appointed home manager will ensure that all team meetings have details and accurate account of discussions contained within.	Home management are responsible to ensure relevant accurate information is minuted from team meetings. Regional management will review this with all home managers at next management meeting [28.09.23] Compliance Manager will review minutes to ensure they contain details of discussions that occur and are of high quality.
6	The registered provider must ensure that supervision of staff, debriefs and post crisis reviews occur in line with	Since 10.07.23 3 weekly supervision is in place for staff. Home management are completing debriefs and post crisis reviews as soon as practical following an incident. These	It is home managements responsibility to complete supervisions, debriefs and post crisis reviews. Where there are any difficulties, they are required to escalate this to regional management.

	the organisations policy and the National Standards for Children's Residential Centres, HIQA (2018) to ensure staff are supported and practice issues are addressed as required.	are completed and reviewed in line with National Standards and the organisations policy and procedure.	Regional management will discuss this at next management meeting 28.09.23 Regional management have reviewed the weekly operations to enable them to have increased oversight and governance on the completion of supervision for all staff. Compliance Manager will conduct audits to ensure supervisions, post crisis reviews and debriefs are completed in line with policy.
	The registered provider must ensure that all efforts are made to provide consistency in the staffing within the centre in line with the best interests of the young people and that in the absence of the core team being able to fulfil the rosters that a plan is developed to minimise the	The centre currently have a full consistent staff team that comprises of home manager, deputy home manager, and a core team that comprises of 7 full time staff members, two part time staff members, one bank staff and one house parent (16hrs per week). There is currently one young person residing in the home.	Workforce planning takes place weekly. As part of this process, the centre are due to receive another full time staff to their team from next induction. Additional support is being provided to staff via supervision and support from the therapeutic support team which includes training, practice review. The staff team are due to receive reflective practice spaces once every two months from an external consultant as a further additional support to the team.

	number of different staff working within the centre. The register provider must ensure that the centre has sufficient and appropriate staffing and management personnel to comply with Child Care (Standards in Children's Residential Centres) Regulations 1996, Part III, Article 7: Staffing	The centre have a newly appointed experienced home manager, Deputy home manager along with a consistent core team with appropriate qualifications.	As part of work force planning, where there are staff deficits in a home, these will be prioritised for allocation of new employees to ensure consistency within the home. Where staffing levels fall below the required standard, we will inform registration and inspection and provide an action plan to address.