



**SOCIAL SERVICES  
INSPECTORATE**

A  
CHILDREN'S RESIDENTIAL CENTRE  
IN THE  
HSE, Dublin North East

**FINAL**

*INSPECTION REPORT ID NUMBER: 162*

Publication Date: 4<sup>th</sup> October 2006  
SSI Inspection Period: 8  
Centre ID Number: 14

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# 1. Analysis of Findings

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Health Service Executive, Dublin North East Region under Section 69 (2) of the Child Care Act 1991.

The centre was located in a small housing estate close to a town. The centre is one of four that provided a regional service for the three Local Health Office (LHO) areas of Louth, Meath and Cavan/Monaghan. The centre had capacity for six children and young people of mixed gender. At the time of inspection there were three boys and two girls, aged between 11 and 17 years.

Inspectors found evidence that this centre had been providing a good service. In the year prior to inspection a number of factors combined to impact on the quality of care provided in the centre. The main factors were the challenging behaviours of some of the young people newly admitted to the centre and the staffs' ability to manage this behaviour. The centre had previously been inspected in January 2001. The majority of the recommendations had been implemented. This resulted in improved practice particularly in relation to the provision of formal supervision for staff, the provision of improved co-ordinated specialist services and a dedicated aftercare service for the young people. However, some of the deficits in the areas of child protection, safeguarding, monitoring of standards and the complaints procedures which were identified then still required a response from the centre staff and line management. At the time of inspection, there was evidence of good practice by a committed, caring and dedicated team of care staff. However, weaknesses in key areas such as management and safe care practice impacted on the capacity of the centre staff team to ensure the safety and well being of the children and young people in the centre.

## *Practices that met the required standard*

The accommodation was of a high standard and praised by the children, young people and parents. It consisted of two, two-storey semi detached houses with a combined living area and a large back garden. Children, young people and parents told inspectors that they liked the fact that the centre looked like any other house in the estate. Inspectors observed the children and young people and their friends from the local estate playing football matches in the garden. The garden area was also used for other sports, meals and BBQ's. The standard of furnishings and fittings were good. The maintenance of the centre was carried out by local contractors. The young people had individual rooms, boys in one of the houses and the girls in the other, with combined living space on the ground floor. The children and young people had choice in decorating their rooms and had personalised them.

The food was of a high standard. The centre had the services of a cook/housekeeper three days a week, who provided home cooking and this was appreciated by the children and young people. They could assist in the shopping and preparation of meals and they could prepare snacks as required. The kitchen/dining area had two large family tables and children and young people, staff, visiting parents and others shared meals.

Care staff shared written information with the children and young people. Inspectors saw evidence of daily logs that were written and signed by some of the children and young people. The children and young people could access their care files, subject to certain restrictions relating to the protection of third parties.

The children and young people were visited regularly by their supervising social workers and they saw the children and young people in private. One of the children who did not wish to meet with or see his social worker at the time of inspection has recently had another

social worker assigned to work with him. Another young person had been allocated a social worker at the time of inspection following a period where the social work team leader had been acting as case manager. There was a good level of contact and communication between centre staff and social workers. Social workers were aware that they could read centre records but only one of them had done so.

Practice in relation to leaving and aftercare was of a high standard. There was a dedicated aftercare service in each of the local LHO areas which had been developed since the last inspection. Three of the young people interviewed had an aftercare worker assigned to work with them and inspectors saw evidence of clear aftercare planning and good interagency co-operation. One of the young people who moved on from the centre in the week prior to inspection, told inspectors that he could contact his aftercare worker if and when he needed support. One of the young people had attended a young persons' advisory and support group, run by young people who had left care.

There was a good standard of key working where a named staff member worked with individual children and young people on key issues. The key worker system had been revised prior to inspection and staff told inspectors that whilst the changes were very recent they were positive about improved outcomes for the children and young people.

Practice in relation to vetting of staff was generally good but there were not the required three references for all staff. One member of staff employed since 2004, had only two of the three necessary references. Inspectors recommend that any outstanding references are sought where it is two years or less (at time of inspection) since the person was first employed.

*Practices that met the required standard in some respect only*

The purpose and function of the centre was to offer medium to long term residential care for six children and young people of mixed gender, aged 11 years to 15 years on admission. The procedure for referral and admission was clear and decisions about placements were generally planned with local centre managers and regional residential management personnel. However, inspectors were of the view that there were three issues arising from the current stated purpose and function that need to be reviewed. The first is the placement of children under 12 in residential care. Despite local HSE policy, the Inspectorate recommends that the practice of placing children under 12 in residential care is reviewed. The second relates to inspector's findings that the wide age range and varying needs of the children and young people impacted on the staff's ability to work effectively and safely with them. The final issue that required a review of the purpose and function related to the discharge of young people from the centre when they reach their 18th birthday, even where they were in full time education and training at this time. The policy needs to change to allow young people who turn 18 and are in full time education or training, who wish to stay in the centre until a natural break, e.g. after exams occur, to do so.

There was a good management structure in place. Supervision and support for the centre manager by the deputy manager for residential services took place on a regular basis. There were weekly staff meetings and the regional residential deputy manager also attended these meetings on a fortnightly basis. The centre manager attended weekly meetings with other local centre managers, deputy managers and the director of the regional residential services. Most staff received regular supervision and there was an on-call structure in place for out of hours and weekends which was provided by the local centre managers on a rota basis. Staff had access to in-service training and were satisfied with the support of centre management in accessing specific training programmes. However, despite the management structure in place and the number of management meetings that took place inspectors were of the view that there were deficits in the following areas: risk assessment of referrals to the

centre, organisation of the staff roster, management of staff, safeguarding and child protection and some inflexible care practices.

All referrals to the centre came through the referral and admissions committee. Whilst social workers completed written referrals which were submitted to the committee they were not made aware of the mix of children and young people in the centre which could impact on the welfare of the child or young person for whom they were responsible. At the time of inspection some children and young people were involved in unsafe behaviours. The admissions and discharge committee needs to ensure a risk assessment of all future referrals to the centre is carried out to assess if and how they may impact on the safety of the children and young people residing in the centre.

The staff team comprised of the centre manager and eight fulltime child care posts, made up of four child care leaders and four child care staff. One staff member was male. They were assisted by an established staff relief panel that contributed to the core staffing hours and covered for sick leave and annual leave. The staff team were committed to the children and young people, making every effort and demonstrating great patience in trying to manage a very busy centre and at times very challenging behaviour. However, inspectors found evidence that there were inadequate numbers of staff rostered daily in the centre to meet the safety and general needs of the children and young people. Whilst the staff rota facilitated a third member of staff to be on duty from 2pm until 11pm, inspectors found evidence that over a two week period in the month prior to inspection, there was only three occasions when a third staff member was present in the centre after 6pm. Inspectors were advised that the shortages were due to a combination of factors; annual and sick leave; parental leave; exam leave; health and safety issues and a limited pool of relief staff. Following inspection, local residential management have advised inspectors that they have successfully completed a recruitment drive over the summer period.

The children and young people told inspectors that they would like staff to be more available to do activities with them, day trips out of the centre and “key worker expeditions” but because of staffing numbers it was very difficult to plan for activities outside the centre. The children and young people also expressed their frustrations at staff not being available because of their requirements to complete daily logs on a quarterly hour basis in some situations. Inspectors recommend an urgent review of the purpose and format of daily recording in the centre in order to ensure that staff are deployed and available to engage in a purposeful way with the children and young people to meet their needs.

Staff described a period in the year preceding inspection where staff morale and energy was very low. This followed a time where three young people had been absent without authority and engaged in risky behaviours on an on-going basis. Some staff told inspectors that following the discharge of some of the young people staff expressed the need for external facilitation and debriefing from local management, and identified the need for more specialised training in difficult and challenging behaviour. The centre manager and line managers told inspectors that some staff had stated that their previous experiences of external facilitation had not met their demands and had decided that the best approach was to look at the issues as a team and a team social event was organised. However, inspectors were of the view that a more direct, comprehensive and professional approach was required to assist staff members to assess the impact of the challenging work situation over the previous period.

The children and young people told inspectors they had choices in relation to food, clothes, holidays and activities. Weekly children’s meetings were held in the centre and children’s and young people’s views were sought by individual key workers. However, the practice in relation to children’s rights was not satisfactory and the scope and methods of consultation require review for three reasons:

- 1) There should be a greater sensitivity to issues that matter to the children and young people. Some of the children and young people brought to the attention of inspectors their repeated request to get the front door bell repaired in the six months prior to inspection. However, these repairs were not carried out at the time of inspection.
- 2) There should be greater openness to changing established practices. There was a belief amongst some of the young people that there was no scope to review established practices in the centre. These included the amount of pocket money, opportunities for the older young people to watch age-appropriate TV programmes, have different bedtimes, have access to or monies for essential and personal items as required and access to a key to their bedroom and to the front door.
- 3) There should be age-appropriate ways of consulting with children and young people. Some of the older children said that the “children’s” meeting was not a suitable forum for them given the age and the differing needs of the younger children.

Children, young people and their parents or carers were consulted and invited to participate in the care planning process. Up to date care plans were in place for all but one of the children and young people in the centre. However, written copies of care plans had not been sent to the centre until the week of inspection. Minutes of meetings, decisions reached and childcare reviews held in the months preceding inspection, were still outstanding in respect of some of the children and young people. This matter must be remedied without delay. Written care plans were to a good standard but there was a weakness in the actual implementation and review of some of the plans. Inspectors were concerned that despite a written plan to explore foster care or affect a return to home, there was no evidence of any action on the plan. The plans, in some instances had not succeeded in the appropriate actions being taken in relation to a child’s or young person’s future.

The resource for children and young people to access specialist emotional support was good. The residential services in the region had recruited a senior psychologist in September 2005. He attended staff meetings on occasions and the staff team had access to him for advice and consultation. They considered this to be very valuable in helping them to improve and reflect on child care practice. Part of his role was to provide psychological assessments and programmes for the children and young people as required. The psychologist and centre staff told inspectors that this work in respect of three of the children and young people had not commenced. This was due to confusion about how to make a referral to the psychologist. Inspectors recommend that the psychologist develop clear procedures for referrals and ensures that this information is made known to all concerned, particularly social workers. In addition inspectors recommend that procedures for the notification of meetings that the psychologist is required to attend and take part in are reviewed.

The centre had an allocated and adequate budget in line with all other units of the service in the local HSE region. However, inspectors consider that certain inflexible budgetary requirements and practice adopted by the centre and line management had a direct impact on care practices and general well being of the children and young people. These included, (1) cutbacks on the use of relief staff, (2) the lack of funds available to purchase a car for use by the centre, (3) pocket money allowance for children not being reviewed despite requests by staff, children and young people, (4) lack of an adequate budget for activities and (5) getting ‘take away’ food been reduced from a weekly to a monthly occurrence. The children, young people and some social workers expressed their frustrations regarding the impact of the budgetary measures on the care provided to the children and young people. Inspectors recommend an evaluation of budget management in the centre to ensure

adequate funding is available for activities and personal needs of the children and young people.

Staff made good efforts to support and facilitate family contact where possible. Inspectors were told by some parents, family members and carers that they are welcome to visit the centre, partake in meals and special occasions. However, inspectors found it unacceptable that one of the parents of a young person, who had lived in the centre for almost four years, visited the centre for the first time for the purpose of meeting with the inspectors. Whilst staff had told inspectors that they were respecting the specific wishes of the young person, every effort should have been made to promote and facilitate purposeful access with this parent. The parent told inspectors that she had not seen a picture of the centre nor had she received any school reports, photographs of holidays or special events involving her child since her placement in the centre. Inspectors recommend that training for staff in ethnic diversity and the development of a strategy to promote and ensure regular contact and access between parents and young people where there are specific difficulties. Another child told inspectors that she would like to have spoken with her mother since her placement in the centre two weeks previously but she had no contact number for her. Inspectors found no evidence to state there was any reason why this child could not contact her mother. It is unacceptable that the child was not encouraged to telephone her mother.

This centre was visited by the Health Boards' (now HSE) monitoring officer in 2003. The monitoring officer had responsibility for eight residential centres, a high support unit, the inspection and registration of non-statutory residential centres in the local HSE area and duties in relation to foster care. She undertook investigation and other duties as assigned. She completed a review of an individual child whose foster carer had concerns in relation to practices in the centre in March 2006, and this was signed off in May 2006. Four weeks prior to inspection she completed an investigation of a complaint made by a young person who had left the centre. The monitoring officer was in contact with the centre on three occasions from September 2004 to June 2005 in relation to management of behaviour and care planning. Seven weeks prior to inspection an acting monitoring officer was appointed to the position whilst the permanent monitoring officer was on leave. She had visited the centre, met with staff, children and young people and some parents. Inspectors were concerned that the centre had not been monitored for some time with specific regard to ongoing safeguarding concerns in the centre. Inspectors recommend that all residential centres should be monitored on a regular basis.

The centre had developed good links with local school placements. This assisted speedy placements for children and young people who moved to the centre and had to relocate schools. Up to a month prior to inspection all the children and young people had appropriate school or training placements. However, in the month prior to inspection, despite the efforts of staff and aftercare workers, two young people in the centre had not attended school or a training placement on any consistent basis. This refusal to attend school or training placements was an integral part of these young peoples' overall challenging behaviour.

There was a good standard of primary health in the centre and all of the children and young people had medical cards and access to local GP's. However, inspectors found little evidence of medical histories for the children and young people. In addition inspectors considered that because of the wide ranging ages and mix of children and young people, there was a particular need for advice and guidance in areas of children and teenage health issues.

A new fire alarm system had been installed in the centre six days prior to inspection. Some staff had been trained in its operation; however, the remaining staff had not had an opportunity to become familiar with the new system.

### *Practices that did not meet the required standard*

Inspectors were of the view that at the time of inspection the safety of the children and young people in the centre was compromised. This was primarily due to the challenging behaviour of some of the children and young people. However, inspectors are of the view that the failures to prevent and control these behaviours relate to a number of weaknesses in the service provided, particularly in relation to notification of child protection and significant events, dealing with complaints, the monitoring function and supervision of the children and young people.

There was a good complaints policy in place and the children and young people were given information about the complaints procedure. However, inspectors found evidence of deficits in the practice of the complaints policy. The children and young people expressed a lack of confidence in the procedures; some of them said that they would not bother to tell a staff member if they had a complaint as they could not do anything about it. Some of the complaints made by the children, young people and parents were not processed through a formal complaints procedure; some of them were recorded in significant event notification forms. In addition a young person told inspectors that whilst he was encouraged to write up a formal complaint which was followed up through the complaints procedure, he did not receive a formal response or an apology. Inspectors recommend, as a matter of priority, a complete revision of how the complaints procedure is put into practice, in consultation with the children and young people.

There were 34 recorded unauthorised absences in the 12 months prior to inspection. Some involved overnight absences. Staff successfully negotiated with one of the young people, encouraging her to take more responsibility for her behaviour. This reduced the number of unauthorised absences for this young person to one in the five month period preceding inspection. Despite the best efforts of staff to manage difficult, violent and challenging behaviour, there were a number of recorded significant events and incidents in the centre which were of great concern to inspectors. Firstly, staff told inspectors of occasions when they could not keep themselves or the children and young people safe because of violent and aggressive behaviour of one of the young people. Secondly, the children and young people told inspectors that they were worried for the safety of the staff and referred to a specific incident concerning one member of staff who had been threatened with assault by one of the young people and another young person intervened to prevent this happening. Finally, staff told inspectors that following an incident where one of the children was abusive and pushing staff, staff retreated to the office to ensure their safety and to call the gardai, whilst other children and young people were upstairs in their rooms. Staff frequently involved the Gardai to assist in managing the behaviour of two of the children and young people. Inspectors were concerned that the children and younger teenagers were copying the behaviours of the older teenagers. Inspectors were also of the view that if the young peoples' attendance at school and training was effectively managed this would have led to a decrease in the overall behavioural difficulties in the centre. Inspectors recommend that a risk assessment is carried out in the centre on the impact of violence and challenging behaviour by some of the children and young people on the emotional and mental health of all children and young people. There was inappropriate reliance on the Gardai and an inappropriate approach to the management of the behaviour of the children and young people. A much more authoritative approach to behaviour management is required and centre staff, working in partnership with the children and young people, should maintain a safe home through the setting of clear boundaries and expectations and using their authority appropriately.

Inspectors considered that the main concern relating to safeguarding was the approach to behaviour management and related issues. The written policy on safeguarding was not

clear. Due to the complexity of children's and young people's needs, centre staff need to be vigilant in observing and recording age and gender appropriate behaviour. This is particularly an issue for some of the more vulnerable younger children. Two of the children and young people told inspectors that they were afraid to tell staff if they were worried, involved in incidents of inappropriate behaviour, being bullied or giving information about another young person as they were afraid of retaliation by a young person in the centre. Whilst centre staff and the children and young people said that they did not believe that there was bullying in the centre, inspectors found records where a child had told staff that he was threatened that he would be killed if the young person with whom he was involved in an incident, discovered that he had told staff about the incident.

In the month preceding inspection, staff supervision levels were increased to ensure the safety of children and young people following a specific incident. Inspectors were of the view that the immediate supervision and safeguarding requirements for this group of children and young people were such that the staff rota needed to be revised to ensure staff were present at the busiest times to optimise the levels of supervision and safety in the centre. In addition centre and line management need to have an ongoing awareness of potential risks to children and young people at these times and if a serious risk is identified be prepared to consider the need for additional or waking staff.

There was a comprehensive child protection policy for all residential child care services and high support residential services in the region. Staff had attended multidisciplinary training in Children First and were aware of the reporting procedures. In reviewing several incidents that occurred in the three months prior to inspection, inspectors were concerned about the effectiveness of the child protection systems and practice in place, for example, with regard to one of these incidents staff did not differentiate the child protection factors when a child made a complaint. The incident was treated as a behavioural issue and notified as such. The details recorded on the significant event notification form were such that the social workers did not respond to the actual risk. The child was not brought to the GP despite complaining of being sore. When the child protection factors were recognised, key information was not shared with all key professionals, and there was confusion regarding the completion of the assessment. The lack of awareness and understanding of what constituted a significant event was inherently connected to the deficits in the child protection system. Whilst staff notified social workers of child protection issues as significant events, social workers then did not respond to the child protection aspects of the event. In addition social workers told inspectors of incidents notified to them by the centre where the information recorded did not prompt them to follow up and respond to the incidents with the level of seriousness they later realised was required. The format used to notify significant events was also confusing. There were incidents which were recorded on the "Incident/Near Miss, Hazards and Complaints Report" forms and also on the local HSE Significant Event Notification Form. There were other occasions when only one of the forms was completed or in some situations the complaints procedure was activated in response to a significant event.

Whilst the local HSE policy is to notify centre and line management, the allocated social work personnel and the monitoring officer of significant events, the acting monitoring officer told inspectors that she was not notified of two significant events that had happened in the centre in the six weeks prior to inspection. Inspectors recommend that there is an agreed understanding of what constitutes a significant event. Inspectors also recommend that there is an agreed format for recording and notification of significant events and child protection concerns and that this format is put in place as a matter of priority.

## *Summary*

The manager and staff team demonstrated a commitment and resilience in caring for the children and young people and inspectors observed good relationships between them. A combination of factors at this time, in particular the range of ages and presenting needs of the children and young people, impacted on the quality of care found during this inspection. Children and young people were placed in the centre without a risk assessment of the impact of the diverse and challenging behaviours. The centre also needs to improve some practices to ensure the standard of day to day care is brought up to the level of National Standards. The lack of identification of risk by external and internal management led to inadequate staffing levels and staff rostering, lack of attention to complaints and a low threshold for identifying child protection concerns. This meant that at the time of the inspection, the safety of the children and young people was not fully met.

## 2. Introduction

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the HSE, Dublin North East Region. Mary Tallon (lead inspector) and Nuala Ward (support inspector) conducted the inspection over a four-day period from the 26<sup>th</sup> – 29<sup>th</sup> of June, 2006.

### 2.1 Methodology

The inspectors had access to the following documents during the inspection:

- The centre's statement of purpose and function
- The policy and procedure document for the residential child care services in the region.
- Copy of admission and discharge register
- Confirmation of insurance
- A health and safety statement (May 2006)
- A health and safety audit (September 2005)
- Completion certificate for new installation of fire detection and alarm system (June 2006)
- Census forms for young people
- Census form for staff
- Details of unauthorised absences (34) and physical restraints (0) for previous 12 months
- The young people's care files
- Completed questionnaires from social workers (4), teachers (2), and 2 letters from G. P.'s.

In the course of the inspection, inspectors met:

1. Five young people
2. Two parents
3. The centre manager, and five members of the care staff team
4. Five social workers and a team leader
5. Two after care workers
6. The acting monitoring officer
7. A psychologist working with the regional residential service
8. The external line manager
9. The regional manager for residential child care services
10. The director of governance, evaluation and planning

The lead inspector had telephone contact with a family member, two parents and a guardian ad litem.

## 2.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the children and young people, their families, the manager and staff of the centre, the social workers, psychologist, aftercare workers and external managers and others who participated in the inspection.

## 2.3 Management structure

The centre manager reported to the deputy director of the regional residential child care service. The deputy director reported to the director. The service was under the general direction of the regional director of governance, planning and evaluation for children and families.

## 2.4 Data on young people in the centre

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
# 1 (male) *	18	Care Order	6 years	1 foster care and 1 residential placement
# 2 (female)	18	Care Order	3 years 9 months	None
# 3 (male)	17½	Voluntary agreement	2 years 9 months	3 foster placements
#4 (male)	13	Voluntary agreement	1 year	2 foster placements and 3 residential placements
# 5 (male)	11	Interim Care Order	11 weeks	1 foster placement
# 6 (female) *	11	Care Order	One week	3 foster placements

\* = Between the time of the census and the inspection fieldwork, one young person, aged 18 was discharged from the service and one young person aged 11 had been admitted.

### 3. Findings

#### 3.1 Purpose and function

##### Standard

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Purpose and function		√	

##### Recommendations:

1. The HSE Dublin North East should review the practice of placing children under 12 in residential care.

#### 3.2 Management and staffing

##### Standard

The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Management		√	
Register	√		
Notification of significant events		√	
Staffing (including vetting)		√	
Supervision and support		√	
Training and development		√	
Administrative files		√	

##### Recommendations:

2. The HSE Dublin North East should ensure that the current management style is reviewed in order to allow for more effective management of the centre.
3. The HSE Dublin North East should develop an effective format for recording and notification of significant events.
4. The HSE Dublin North East should ensure that adequate information is provided in the significant event notification form to allow identification of child protection concerns.

5. The HSE Dublin North East should ensure staff are available to provide care and instruct them on the information required for entry into daily logs.
6. The HSE Dublin North East should ensure that there is adequate staffing levels and staff are deployed in a manner that meets the needs of the young people for stability and safety.
7. The HSE Dublin North East should ensure that staff receive further direction, training and support in managing out of control and challenging behaviours.
8. The HSE Dublin North East should strive for, as far as is practicable, a balance of female and male staff members on the team.

### 3.3 Monitoring

#### Standard

The health board, for the purposes of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the health board to monitor statutory and non-statutory children's residential centres.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Monitoring		√	

#### Recommendations:

9. The HSE Dublin North East should ensure that the centre is regularly monitored and that monitoring visits are responsive in relation to the management of behaviors and complaints.
10. The HSE Dublin North East should ensure that the monitoring officer is notified of significant events as they occur.

### 3.4 Children's rights

#### Standard

The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Consultation		√	
Complaints			√
Access to information	√		

#### Recommendations:

11. The HSE Dublin North East should improve practice in relation to children's rights.
12. The HSE Dublin North East should review, in consultation with the young people, and the findings of this inspection, the current complaints procedures and practice in the centre.

### 3.5 Planning for children and young people

#### Standard

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Suitable placements and admissions		√	
Statutory care planning and review		√	
Contact with families		√	
Supervision and visiting of young people		√	
Social work role		√	
Emotional and specialist support		√	
Preparation for leaving care	√		
Aftercare	√		

#### Recommendations:

13. The HSE Dublin North East should immediately review the placements of the current residents who are 12 and under and carry out a risk assessment in respect of all future referrals.
14. The HSE Dublin North East should ensure that social workers read centre records from time to time.
15. The HSE Dublin North East should ensure that social workers forward care plans, minutes of child in care reviews and other meetings to the centre without delay.
16. The HSE North East should ensure that every effort is made to promote and facilitate contact between parents and young people, keeping them informed and involved in all aspects of their children's lives.
17. The HSE North East should ensure that children and young people have early access to the dedicated psychology service.

### 3.6 Care of young people

#### Standard

Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Individual care in group living		√	
Provision of food and cooking facilities	√		
Race, culture, religion, gender and disability		√	
Managing behaviour			√
Restraint		√	
Absence without authority		√	

#### Recommendations:

18. The HSE Dublin North East should revise the centre's daily budget, in consultation with the young people, to ensure adequate funding is available for activities, pocket money and personal needs of the young people, with specific regard for after hours and weekends.
19. The HSE Dublin North East should ensure that essential and personal items are available for the young people as required.
20. The HSE Dublin North East should provide training for staff in promoting practice that reflects and supports the young people's cultural and ethnic identity.
21. The HSE Dublin North East should, as a matter of priority, undertake risk assessments in managing children and young people's behaviours. The risk assessment should be monitored by external line management.

### 3.7 Safeguarding and Child Protection

#### Standard

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Safeguarding and child protection			√

#### Recommendations:

22. The HSE Dublin North East should, as a priority, revise current safeguarding practice.

### 3.8 Education

#### Standard

All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate educational facilities.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Education		√	

#### Recommendation:

23. The HSE Dublin North East should ensure that children and young people in their care attend school or training.

### 3.9 Health

#### Standard

The health needs of the young person are assessed and met. They are given information and support to make age appropriate choices in relation to their health.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Health		√	

#### Recommendations:

24. The HSE Dublin North East should ensure that there is an up to date comprehensive medical history available for each young person.
25. The HSE Dublin North East should ensure there is an ongoing programme available for the young people on teenage health issues.

### 3.10 Premises and Safety

#### Standard

The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 & 13 of the Child Care Regulations, 1995.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Accommodation	√		
Maintenance and repairs	√		
Safety	√		
Fire safety		√	

#### Recommendations:

26. The HSE Dublin North East should ensure that all staff are familiar with and trained in the new fire alarm system in the centre.
27. The HSE Dublin North East needs to provide written confirmation that all statutory requirements relating to fire safety and building control have been complied with as required by standard 10.19.

#### 4. Summary of recommendations

1. **The HSE Dublin North East should review the practice of placing children under 12 in residential care.**
2. **The HSE Dublin North East should ensure that the current management style is reviewed in order to allow for more effective management of the centre.**
3. **The HSE Dublin North East should develop an effective format for recording and notification of significant events.**
4. **The HSE Dublin North East should ensure that adequate information is provided in the significant event notification form to allow identification of child protection concerns.**
5. **The HSE Dublin North East should ensure staff are available to provide care and instruct them on the information required for entry into daily logs to**
6. **The HSE Dublin North East should ensure that there is adequate staffing levels and staff are deployed in a manner that meets the needs of the young people for stability and safety.**
7. **The HSE Dublin North East should ensure that staff receive further direction, training and support in managing out of control and challenging behaviours.**
8. **The HSE Dublin North East should strive for, as far as is practicable, a balance of female and male staff members on the team.**
9. **The HSE Dublin North East should ensure that the centre is regularly monitored and that monitoring visits are responsive in relation to the management of behaviors and complaints.**
10. **The HSE Dublin North East should ensure that the monitoring officer is notified of significant events as they occur.**
11. **The HSE Dublin North East should improve practice in relation to children's rights.**
12. **The HSE Dublin North East should review, in consultation with the young people, and the findings of this inspection, the current complaints procedures and practice in the centre.**
13. **The HSE Dublin North East should immediately review the placements of the current residents who are 12 and under and carry out a risk assessment in respect of all future referrals.**
14. **The HSE Dublin North East should ensure that social workers read centre records from time to time.**
15. **The HSE Dublin North East should ensure that social workers forward care plans, minutes of child in care reviews and other meetings to the centre without delay.**
16. **The HSE North East should ensure that every effort is made to promote and facilitate contact between parents and young people, keeping them informed and involved in all aspects of their children's lives.**
17. **The HSE North East should ensure that children and young people have early access to the dedicated psychology service.**
18. **The HSE Dublin North East should revise the centre's daily budget, in consultation with the young people, to ensure adequate funding is available for activities, pocket money and personal needs of the young people, with specific regard for after hours and weekends.**

- 19. The HSE Dublin North East should ensure that essential and personal items are available for the young people as required.**
- 20. The HSE Dublin North East should provide training for staff in promoting practice that reflects and supports the young people's cultural and ethnic identity.**
- 21. The HSE Dublin North East should, as a matter of priority, undertake risk assessments in managing children and young people's behaviours. The risk assessment should be monitored by external line management.**
- 22. The HSE Dublin North East should, as a priority, revise current safeguarding practice.**
- 23. The HSE Dublin North East should ensure that children and young people in their care attend school or training.**
- 24. The HSE Dublin North East should ensure that there is an up to date comprehensive medical history available for each young person.**
- 25. The HSE Dublin North East should ensure there is an ongoing programme available for the young people on teenage health issues.**
- 26. The HSE Dublin North East should ensure that all staff are familiar with and trained in the new fire alarm system in the centre.**
- 27. The HSE Dublin North East needs to provide written confirmation that all statutory requirements relating to fire safety and building control have been complied with as required by standard 10.19.**