



**SOCIAL SERVICES
INSPECTORATE**

**A CHILDREN'S RESIDENTIAL CENTRE IN
THE WESTERN HEALTH BOARD
MAYO COMMUNITY SERVICES AREA**

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ADDRESS: Social Services Inspectorate, Floor 3, 94 St. Stephens Green, Dublin 2

PHONE: 01-4180588 FAX: 01-4180829

WEB: www.issi.ie

Contents:

1. **Executive Summary**
2. **Introduction**
 - 2.1 *Methodology*
 - 2.2 *Acknowledgements*
3. **Setting the scene: the centre; background and its population**
 - 3.1 *Data on children/young people*
 - 3.2 *Details of previous placements (including present placement)*
 - 3.3 *Management structure*
4. **Standards: the findings**
 - 4.1 *Statement of purpose and function*
 - 4.2 *Working in partnership*
 - 4.3 *Admissions criteria and policy*
 - 4.4 *Care planning and review*
 - 4.4.1 *Care plans*
 - 4.4.2 *Review of care plans*
 - 4.4.3 *Family involvement*
 - 4.5 *Staff recruitment and support*
 - 4.5.1 *Recruitment*
 - 4.5.2 *Staffing*
 - 4.5.3 *Length of services of staff*
 - 4.5.4 *Staff rota*
 - 4.5.5 *Qualifications of staff*
 - 4.5.6 *Staff support and supervision*
 - 4.6 *Children's rights*
 - 4.6.1 *Consultation*
 - 4.6.2 *Complaints procedures*
 - 4.6.3 *Access to information*
 - 4.7 *Child protection and safeguarding issues*
 - 4.8 *Sanction policy*
 - 4.9 *Unauthorised absences of young people*
 - 4.10 *Ethos and quality of care*
 - 4.10.1 *Living skills*
 - 4.10.2 *Psychological and emotional development*
 - 4.10.3 *Preparation for leaving care*
 - 4.10.4 *Physical aspects of the centre*
 - 4.10.5 *Respect for child's privacy, dignity and individuality*
 - 4.10.6 *Education*
 - 4.10.7 *Health*
 - 4.11 *Administration*
 - 4.11.1 *Fire precautions*
 - 4.11.2 *Insurance*
 - 4.11.3 *Young people's records*
 - 4.11.4 *Administrative records*
 - 4.11.5 *Safety*
 - 4.11.6 *Maintenance of register*
 - 4.11.7 *Supervision and visiting of young people*
 - 4.11.8 *Monitoring*
 - 4.12 *Physical restraints*
5. **Summary of recommendations**

1. Executive summary

This section summarises the main findings and conclusions of the inspection report on Aglish House, a children's residential centre run by the Western Health Board. For a more detailed analysis of the points raised readers are referred to the relevant section of the report.

Aglish House was, at the time of inspection, home to 4 young people aged between 5 and 16 years. All of the residents were in voluntary care.

Aglish House is based in rented premises in a housing estate in Castlebar. The house is similar in appearance to other houses in the neighbourhood and enjoys the advantage of proximity to the town centre, schools and local facilities. There is a 'for sale' notice outside the house. The WHB has identified a site for a new purpose built unit to replace the existing centre.

Aglish House was originally set up by Castlebar Social Services to provide a service to one particular family. It was taken over by WHB in 1998. Its function is to provide short term residential care for up to 6 young people aged up to 18 years from County Mayo. It is the only children's residential centre in the county.

The provision of residential child care in WHB is changing. The board is taking over units formerly run by the voluntary sector and religious orders. The numbers of children in County Mayo in residential care has been dramatically reduced over the past few years, from 30 in 1997 to just 10 in 2000. The management of services is under review with the aim of integrating residential services with other health board child care services.

WHB engaged a consultant to review its children's residential services. The consultant's report was complete but had not yet been released to the board at the time of inspection. Notwithstanding this, WHB has a plan to relocate Aglish House to purpose built premises and to provide a second unit in Mayo. Aglish House will become a long term unit, while the new unit will provide short term care. This is a welcome development as currently Aglish experiences difficulty in meeting two incompatible aims. Aglish House is, according to the statement of purpose and function, a short term unit. On the other hand it tries to ensure that children in need of residential care in Mayo do not have to go out of county. The problem arises when a young person from Mayo is in need to long term residential care. This has been resolved by Aglish House departing from its statement of purpose and function and offering long term care to certain of its residents. In addition, Aglish House has admitted young people on an emergency basis while the statement only envisages planned admissions.

The permanent staffing complement for Aglish House is one manager, one houseparent, 5 assistant house parents, one night supervisor and one part time clerical officer. This staffing complement is too low necessitating the use of numerous relief staff. At the time of inspection there were 14 people directly involved in caring for the young people. This number is too high and inconsistent with good child care practice. The complement of permanent staff needs to be increased.

The premises are in poor repair and poor decorative order. It is of particular concern to inspectors that Aglish House does not meet an acceptable standard of fire protection according to WHB's own fire and safety officer. The officer made certain recommendations in 1998 to bring the premises up to the required standard. However, two and a half years later, 4 recommendations relating to escape from the building and emergency lighting had not been acted on. Notwithstanding any plans to move to new premises, it is unacceptable that children and young people are being cared for in a building that is unsafe and does not meet the standards one would expect of an ordinary family home.

Despite problems with staffing and premises, the young people in Aglish House receive a good standard of care. Care planning and reviews are taking place. Children's rights are respected. The residents are given access to information, their views are sought and acted on. The young people can and do make complaints. The relationships between staff and young people in Aglish are positive and purposeful and the young people experience themselves as cared for and respected.

The staff group are committed to offering the highest standard of care. The group contains a mix of experienced and qualified staff. It would benefit from having some male members. Inspectors found some evidence of problems in communication in the staff team that need to be addressed.

The staff team have, in recent times, been stretched and somewhat demoralised by the task of caring for one resident with very particular difficulties that give rise to very hard to manage behaviour. This behaviour has resulted in injuries to at least one young person and several staff. Staff cannot meet this child's needs nor can they guarantee the safety of other residents while he is in Aglish House. A more appropriate placement needs to be found as a matter of some urgency.

Staff in Aglish House have developed good working relationships with their colleagues in the social work department. WHB is to be commended for progress to date in integrating the centre with its child care services. Staff in Aglish also work well with other agencies and professionals.

Family work features prominently and positively in Aglish House. Contact with families is encouraged and parents are involved, as far as possible, in the decisions affecting their children.

Administrative records are maintained to a high standard in Aglish though the young people's files vary in quality.

WHB is to be commended for ensuring that proper monitoring is in place.

Aglish House offers a good overall standard of care to the young people who live there. There are matters that need attention including the house itself, the safety of staff and young people, over reliance on relief staff and staff communication and morale. However, the combination of good standards of care, a committed staff team, an informed and involved external management and regular monitoring of standards give grounds for the belief that these problems can be dealt with appropriately.

2. Introduction

The inspection of Aglish House Children's Residential Centre was carried out by the Social Services Inspectorate under the provisions of Section 69 (2) of the Child Care Act 1991. A pre inspection visit took place on 27th of October when Andrew Fagan met with some staff and all of the young people and explained the purpose of the inspection and how it was proposed to carry it out. The inspection itself was carried out by Mike Lindsay and Andrew Fagan, Inspectors, on November 7th, 8th and 9th, 2000.

2.1 Methodology

During the course of the inspection inspectors met and talked with each of the young people in the centre and a number of their parents. Inspectors interviewed the manager, staff members and social workers who had placed young people in Aglish House. Interviews were also conducted with the principal social worker with line management responsibility for the centre and with the child care manager. The general manager with overall responsibility for Aglish House was unavailable to meet with inspectors due to illness.

Inspectors observed the routines of the centre at various times over the 3 day period.

The following documents were examined:

- The young people's case files
- The daily log books
- The night supervisor's log
- Census forms on staff members
- Census forms on young people
- Questionnaires completed by social workers and one parent
- A monitoring report dated June 2000
- Medication records
- A safety statement, dated 1997
- A visitor's book
- A taxi book (details of journeys undertaken)
- Minutes of staff meetings
- A log detailing who was in residence each day
- A policies and procedures folder.

2.2 Acknowledgements

The inspectors wish to acknowledge the co-operation of the various officers of the Western Health Board. We wish to thank the manager, staff and young people for their considerable assistance.

3 Setting the scene: background, the centre and its population

Aglish House is located at the Currach, a private housing estate in Castlebar, Co Mayo. There is nothing about the premises to distinguish it from other houses in the estate. The house has been rented by the Western Health Board from a private landlord. It is within walking distance of the town centre. Currently there is a 'for sale' notice outside the house as the landlord wishes to dispose of the property. A site for a new purpose built unit to replace Aglish House has been acquired by WHB and plans for the unit are being prepared by an architect in consultation with board staff.

Aglish was originally established as a service for one particular family group in need of care and protection. It was run by Castlebar Social Services. In April 1998 it was taken over by WHB. It provides a service for up to 6 children from Mayo. Currently there are 4 young people in residence and there are no immediate plans for further admissions.

Residential services in the Western Health Board area have traditionally been provided by the voluntary sector and religious orders. This situation is gradually changing. The board now runs two centres and plans to take over the running of a number of other centres currently run by the Sisters of Mercy. In addition to changes in management, there have been changes in the way residential care is used. For instance, while there were 30 Mayo children in residential care in 1997, there were only 10 so placed in October of this year.

The Western Health Board recently engaged a consultant to review all residential services in the board's area. Her report is due to be released shortly. It is anticipated that the purpose and function of the Aglish House unit will change so that it concentrates on offering long term care to 4 young people from Mayo and another, short term, unit will be set up in Mayo.

3.1 *Data on children / young people*

At the time of inspection there were 4 young people in residence, one girl and 3 boys, aged between 5 and 16 years.

3.2 *Details of current and previous care placements*

One resident, aged 5, had been in the centre for 2 years. The other 3 were aged 14, 15 and 16 and had been in the centre 6 months, 4 months and 9 months respectively. All the young people were placed in Aglish by agreement with their parents. Three of the young people had no previous care placements. One had had a number of short term emergency admissions to care prior to placement in Aglish.

3.3 *Management structure and support*

The manager had overall responsibility for the running of the centre. She had some administrative support from a clerical officer who divides her time between Aglish and another work location. Recently a houseparent was appointed and this person deputised for the manager in her absence but the management role of the houseparent had not been defined. The manager worked off shift and was on call on a 24 hour

basis. She received calls regularly in the evenings and at weekends and had been called while on holiday. She had, on occasion, to cover shifts at times like Christmas when it was hard to find relief staff willing to cover shifts. The manager was not paid an on call allowance nor has she claimed time in lieu of the work she has done outside of her normal working hours.

The principal social worker met with the manager for formal supervision. This was supposed to happen on a monthly basis but there can be longer intervals between supervisions sessions. However, it was open to the manager to consult with the principal social worker on an informal basis and this happened frequently, especially in times of crisis. The team leader for residential services provided a monitoring and consultancy service. He has advised the centre in relation to the development of policy and procedure. Recently, he met with the staff team to explain the role of SSI and took the opportunity to hear staff concerns about the impact of the placement of one particular young person in Aglish on staff and the other young people. The child care manager has an input in relation to resource and financial matters.

The management structure of Aglish House needs to be reviewed. The role of the houseparent requires definition so that she can formally assist in management tasks such as supervision rather than merely deputise for the manager in her absence. The demands on the manager, especially on her availability outside her normal working hours, are too onerous. This is acknowledged by senior managers and inspectors understand that this situation is currently under review.

4 Standards: the findings

4.1 Statement of purpose and function

The centre has a clear written statement of purpose and function which accurately describes what the centre sets out to do with children and the manner in which that is provided.

Aglish House had a very comprehensive statement of purpose and function and accompanying policy documents and the manager and health board are to be commended for this.

The policy documents contained a mission statement for Aglish House stating basic principles and objectives for the centre. The statement of purpose and function set out the services provided in Aglish: short term residential care for 6 children from Mayo aged up to 18 years for a maximum of 12 months. In addition Aglish aimed to provide other services such as out reach, respite and after care services. The stated aim is to work in partnership with families towards an early return home of the child or young person or, where that is not feasible, to work towards a suitable long term 'out of home' placement. The statement set out the basic values of Aglish House: respect for the family of the child or young person, for the child's cultural background and for his or her individuality and dignity. Aglish House is committed to respecting the religious beliefs of the young people and their families, to promote the education of the young people and to involve them in social and cultural activities in the locality. There was a section on care planning and review which set out the responsibility of the health board in this regard. There were also sections on health care and child development, staffing, records, admission and discharge policy, unauthorised absences, complaints procedures, confidentiality, serious incidents, child protection and care and control. Although there was no separate section on working in partnership with other agencies and professionals, the first section of the statement stated that Aglish House sees itself as complementing the other services provided by the health board.

The statement of purpose and function and accompanying policies form a useful basis for the work being carried out in Aglish House. They set out clearly the services Aglish was set up to provide and provided guidance for staff in dealing with particular situations.

Particular policies are considered in more detail later in this report. The statement of purpose and function, however, was not reflected in the admissions policy in Aglish House. The statement, indeed, set out two conflicting aims: to offer short term care only and to maintain Mayo children in their home county. The conflict arises when a child from Mayo is in need of long term residential care. Inspectors were made aware of placements in Aglish House lasting between 2 and 4 years. This difficulty may be resolved when the planned second residential unit is established in Mayo.

While the statement envisaged only planned admissions, young people have been admitted on an emergency basis.

The statement made reference to outreach, respite and after care work and inspectors heard of interesting and creative work which had been carried out with young people and their families by staff of Aglish House. It appeared that, at the time of inspection, Aglish House was unable to offer these services due to other demands on staff time.

Aglish House was providing care for one boy with special needs. This necessitated changes to the working rota and the use of additional relief staff. Despite this and other extra resources devoted to the care of this boy Aglish House does not have the capacity to meet his needs for reasons that will be further developed throughout this report. The statement of purpose and function made no reference to Aglish House offering such a specialised service. Other placement options need to be explored for this young person.

Recommendations:

- The statement of purpose and function needs to be revised by the manager in consultation with her line manager and the child care manager. The statement should reflect the fact that Aglish House offers medium to long term residential care for children and young people and will admit them on an emergency basis in particular circumstances.
- The principal social worker and child care manager must ensure that children and young people are not placed inappropriately and that, where an inappropriate placement is all that is available in an emergency, the young person so placed is moved to a more appropriate placement as soon as practicable.

4.2 Working in partnership

Partnership is essential to the provision of good quality residential childcare. The experience of young people in care is enhanced by positive working relationships between professionals.

The principal social worker saw Aglish House as part of an integrated service for children. Inspectors found this to be reflected in practice. Social workers and residential workers clearly saw themselves as operating in partnership to achieve the best possible outcome for the young people in Aglish House. Communication was good and there was no discernible tension in the relationship between the two groups.

A number of the young people were involved with the local Neighbourhood Youth Project and communication between this organisation and staff in Aglish also appeared to be good.

A number of other professionals have been called on to assist staff in looking after one boy with special needs and staff singled out the role of the psychologist involved as helpful and supportive. However, a difficulty seemed to have arisen in relation to obtaining a psychiatric assessment. The consultant psychiatrist was willing to meet with those working with the child but seemed reluctant to meet with the child.

Recommendation:

- WHB needs to ensure that all the professional resources at its disposal are available to meet the needs of the children in its care.

4.3 Admissions criteria and policy

The centre has an established policy, setting out how young people are referred and admitted.

There was an established policy and procedure in Aglish House. The policy document declares that central to the ethos of the unit is that children should enter care in a planned and structured way.

A social worker makes application on a standard form. This is sent to a central admission panel for consideration and decision. Where successful a pre admission visit is arranged involving the young person, his/ her social worker and where possible parent or guardian.

Of the 4 current residents 2 were admitted on a planned basis. One was initially admitted in an emergency and then subsequently transferred to another unit to return in accordance with the established procedure. The other young person was admitted in an unplanned way.

The admissions policy can only be regarded as aspirational and while the situation it envisages is in accordance with good practice it gives no guidance on dealing with emergency or unplanned admissions. The policy needs to specify the circumstances in which young people can be admitted and who can refer them to Aglish House.

Recommendations:

- The admissions policy needs to be revised by the manager to take account of both planned and unplanned admissions. The circumstances in which young people can be admitted without prior referral to the admissions panel need to be clarified.
- The admissions policy, thus modified, needs to be communicated by the principal social worker to those who may wish to make referrals to Aglish House. In particular, the Gardai need to be informed of this policy, given that they have referred a young person to Aglish House in the past.

4.4 Care planning and review

4.4.1 Care plans

Each young person's care is subject to a formal, systematic and written plan to promote the welfare of the child in compliance with Article 23 of the Child Care Regulations 1995.

The statement of purpose and function describes care planning as central to the promotion of good child care. It is commendable that each of the current residents of Aglish House had a care plan and that these plans have been in place since very early in the placement of the young people. For one young person the care plan was not

dated but it was apparent that it had been completed soon after admission. Two young people recently admitted had their care plans completed within two weeks of admission.

The practice was that a care planning meeting took place involving the young person, parent/s, keyworker, residential manager and social worker to formulate the plan. The format of the plan itself varied. In some cases the minutes of the care plan meeting became the care plan. However, in the case of the young person most recently admitted the care plan was written by the young person's social worker on a standard WHB care plan form. This is preferable to the former arrangement. The care plan so produced conformed more closely to the Child Care Regulations in specifying the purpose and aims of the placement, the support available to the child, parents and residential centre and the arrangements for the implementation of the care plan. These issues were not always covered in the other care plans.

The minutes of the care plan meeting were sometimes written by the residential manager. This is unsatisfactory as it appears that this person is responsible for formulating the care plan whereas the responsibility lies within the social work department. Where the standard form was used it was signed by the social worker.

4.4.2 Review of care plans

Each young person's plan is reviewed by an authorised person as often as may be necessary in particular circumstances, but in any event at intervals not exceeding those specified by Article 25 of the Child Care Regulations 1995.

Care plan reviews took place on a regular basis in accordance with the regulations. For the boy who has been longest in the unit his care plan was reviewed every 6 months. A young man admitted in February of this year had a review in April and again in October. There was a review of a young person in July who had been admitted the previous May. The other resident was admitted at the end of June and his review took place in the middle of October. This is slightly outside of the time scale laid down in the regulations but not significantly so.

The young people attended all of their reviews, apart from the youngest resident whose attendance would not have been appropriate. Parents were invited and most did attend. The manager and young person's keyworker attended as did the social worker. On occasion other professionals have also been invited. Some of the young people have stated a preference for not having too many outside professionals involved and objected to, for instance, the presence of a school teacher on grounds of confidentiality. These wishes have been taken into account and acted on, which inspectors find commendable.

Forms were completed in advance by keyworkers and the young people themselves. The health and education of the young people were considered at reviews. However, in two cases inspectors could find no report from the social worker on file prepared specifically for reviews.

It was sometimes unclear what was the focus of the review meetings. Minutes of the reviews suggested that there was a discussion of the young person's general progress rather than a review of the care plan as such. For instance, in none of the minutes of reviews seen by inspectors was any reference made to progress to date in achieving care plan objectives. Reviews only exceptionally set target dates for the completion of identified tasks.

Inspectors commend the board for the presence of care plans and the regularity of reviews. Practice would be further enhanced by standardising procedure for care plan reviews to ensure they refer to the young person's care plan and assess progress in achieving stated aims and objectives.

4.4.3 Family involvement

The centre shows respect for the young person's family in all aspects of how it cares for young people. Parents are involved in planning for young people's everyday life and future.

Parents spoke positively of their contact with Aglish House. They referred to their involvement in care planning and reviews and of their views being taken into account. They spoke about being treated with respect and being made welcome in the unit. One parent clearly finds her relationship with her son's keyworker a source of personal support.

One parent expressed dissatisfaction with the lack of contact between herself and her son. While she believed her son to be well cared for physically she felt staff were not doing enough to repair the rift that had occurred in her family. The young man was referred to a psychologist for counselling in relation to family issues but failed to engage with the counsellor. Clearly the parent in question found it hard to accept that her son was refusing to have contact with her and seemed unaware of the efforts staff had made to encourage him to reconsider his position in relation to this issue.

Family members visited the young people in Aglish and received visits from them in their own homes. One parent stated a preference for seeing her child in her own home. She said that though she was given a room in which to meet with her child in privacy the room was unsuitable and there was little to keep her other children occupied during the visit.

Recommendations:

- The principal social worker should ensure that care plans for the young people in Aglish House are completed on the standard WHB care plan form and that they are signed and dated by the social worker with case responsibility for the young person.
- The WHB should develop a standard care plan review form in line with the standard care plan form to ensure that reviews refer to care plan aims and objectives, assess their implementation and set targets for completion before the next review.
- Suitable facilities should be provided for family members who visit Aglish and senior managers should ensure that these are included in plans for the new purpose built unit to replace the present premises.

4.5 *Staff recruitment & support*

4.5.1 *Staff Recruitment*

Staff are the most vital resource in providing quality care. They will be among the most important people in the child's life while in residential care. Recruitment, training and support policies should recognise this and should ensure that staff are equipped to fulfil their duties to children. The personal and professional skills which staff bring to the task of caring for children should create a living environment which is child-orientated.

Recruitment of permanent staff was done centrally in WHB headquarters in Merlin Park in Galway. Posts were advertised in the national press. Advertisements for relief posts were placed in local newspapers. In addition, sometimes colleges made contact with the manager and nominated people for the relief panel. Candidates were interviewed and references and Garda clearance obtained before any new staff member took up duty.

4.5.2 *Staffing and staff rota*

The staffing complement was one manager, one houseparent, one night supervisor, 5 assistant houseparents, and a part time clerical officer, all permanent posts. There was also provision for relief staff to be employed on a temporary basis. The permanent manager was on a career break until March 2001. Her post was being filled temporarily by a permanent assistant houseparent. One of the assistant houseparents was out on long term sick leave. Her rota 'line' has been taken over temporarily by one of the relief workers. There were 8 relief workers, one of whom is currently an acting assistant houseparent.

At the time of inspection there were 14 staff members involved in working directly with the young people in Aglish. This is not consistent with good child care practice as it can only lead to inconsistency and lack of continuity in the care of the young people. This problem is exacerbated by a constant turnover of relief staff which means more and more new people being introduced to the residents.

Two staff came on duty at 7am. They were replaced by two more at 3 pm. One of these went off duty at 10pm when the night supervisor arrived. The other worker did a sleep over. The night supervisor was on waking duty during the night. She worked 4 nights per week. Other night waking shifts were done by relief workers.

Recently the rota has had to change to meet the need for continuity of care of one of the residents. His two keyworkers have been taken off their rota 'lines' so that one or other of them can be available for most of his waking hours. Night time cover was also been increased at the weekend which has been found to be a particularly difficult time. Two staff were on waking duty on Friday, Saturday and Sunday nights.

4.5.3 Length of service of staff

Staff	Length of service in Aglish House	Length of service in childcare in total
Acting manager (permanent houseparent) assistant	5 years 6 months	5 years 6 months
Houseparent (permanent)	4 weeks	6 years
Assistant houseparent (permanent)	4 years 4 months	4 years 4 months
Assistant houseparent (permanent)	6 years	6 years
Assistant houseparent (permanent)	8 years	8 years
Assistant houseparent (permanent) currently on sick leave	4 years	4 years
Assistant houseparent (temporary)	3 years	3 years
Relief assistant houseparent (temporary)	2 years 8 months	2 years 8 months
Relief assistant houseparent (temporary)	9 months	9 months
Relief assistant houseparent (temporary)	12 months	12 months
Relief assistant houseparent (temporary)	15 months	15 months
Relief assistant houseparent (temporary)	2 years	2 years
Relief assistant houseparent (temporary)	4 years	4 years
Relief assistant houseparent (temporary)	2 weeks	2 weeks
Night Supervisor (permanent)	18 months	7 years
Clerical Officer (temporary, Part time)	15 months	Not applicable

All the staff in Aglish House were female. Several young people and staff expressed a preference for a mixed gender staff team. Male staff would provide role models for the boys in the unit.

Nearly all of the staff except the houseparent have gained all their residential child care experience in Aglish House. Some relief staff members also did relief work for Western Care which offers services for young people with learning difficulties. Overall, however, the staff group was drawing on a relatively narrow range of experience.

4.5.4 *Qualifications of staff*

Staff Member	Qualification
Acting Manager	Currently studying for a Diploma in Applied Social Studies in Social Care
Houseparent	Diploma in Applied Social Studies in Social Care
Assistant houseparent	Diploma in Counselling
Assistant houseparent	National Certificate in Social Studies Advanced Diploma in Child Care
Assistant houseparent	Certificate in Counselling Skills
Assistant houseparent	National Diploma in Applied Social Studies in Social Care
Assistant houseparent (temporary)	No qualification
Relief assistant houseparent	B.A. in Applied Care in Social Care
Relief assistant houseparent	B.A. in Applied Care in Social Care
Relief assistant houseparent	National Diploma in Applied Social Studies in Social Care
Relief assistant houseparent	B.A. in Applied Care in Social Care
Relief assistant houseparent	Higher National Diploma in Social Studies (BTEC)
Relief assistant houseparent	B.A. in Applied Care in Social Care
Relief assistant houseparent	B.A. in Applied Care in Social Care
Night supervisor	Family and Households, Level 2

Eight out of 15 members of staff held a recognised qualification in child care. Assuming that the manager successfully completes her course the number will increase to 9. However, the qualified staff were more likely to be temporary part time staff than full time permanent staff. This led to an imbalance within the team, highlighted by the manager, as a difficulty in blending theory and practice within the staff group.

4.5.5 *Staff support and supervision*

Young people are looked after by staff who are trained in the skills necessary to meet their needs and, who receive appropriate professional support from management for the tasks that they are required to carry out.

There was an induction process for new staff members. They met with the manager who went through house routines, board policies etc and introduced them to the staff on duty and the young people. Following this the new staff member did a 'shadow' shift. This was a shift where the new staff was an extra person, working with two experienced staff members for a period of 3 to 4 hours. The person then did a complete shift not involving a sleep over. After a number of weeks the manager met with the new staff member again and discussed with her how she was settling in. New staff members were expected to acquaint themselves with the contents of the policy and procedures folder.

The WHB recently organised an in service training programme for residential workers involving a number of modules. The first module started in September and runs through until December. It contains 4 training events on different aspects of residential work. When this module is complete residential managers will meet with the childcare manager for Galway to plan the next module.

Training sessions last for one day and are repeated the following day in order to ensure that as many people as possible can attend. On the week of the inspection, there was one such training session on the subject of behaviour management. The manager tried to ensure that as many as possible of the staff, whether permanent or temporary, attended these training events. Staff members were also entitled to apply for funding to attend external training events.

Some staff have been trained in the methods devised by the Crisis Prevention Institute which includes guidance on safe forms of physical restraint. The manager did a course in this and is now a trainer for CPI. Others were trained a number of years ago but their training has not been updated over the last year. Staff need to have their skills updated by attendance at regular refresher courses.

The manager was studying for a professional qualification and inspectors were given to understand that WHB will pay her tuition fees. WHB will also look favourably on requests from other staff members for secondment to recognised training courses.

The manager was supervised by the principal social worker and found this helpful. This was meant to happen on a monthly basis but sometimes occurred less frequently. The principal social worker was available for consultation at other times. The manager was given funding for a number of sessions with an outside consultant in order to help her clarify certain aspects of her role as manager. These sessions, now coming to an end, have been helpful.

The manager supervised the staff in Aglish House. She aimed to offer monthly supervision to all staff but freely acknowledged that this did not happen as planned. Written records of these supervision sessions were made by the manager and these were shared with the staff member concerned. A format was followed with the manager first enquiring as to the staff members health and welfare. Then discussion moved on to consider professional issues. Any issues that arose within the context of the keyworking relationship for those members of staff to whom this applied were also discussed.

Neither the manager nor staff members were entirely happy with the arrangements in relation to supervision. The manager found this aspect of her work difficult and it is one where she lacked confidence. Staff members had differing perceptions. Some relief staff felt that they lost out and preference was given to permanent staff when it came to allocating time for supervision. Permanent staff members referred to difficulties in communication and differing perceptions of the purpose of supervision. These difficulties extended into other aspects of team functioning such as the conduct of the team meetings and informal contacts between the manager and some team members. Inspectors were concerned that some of this discontent was expressed in terms of people's alleged inadequacies or even bad faith. This can only make resolution of these difficulties more problematic. The staff team needs the assistance

of an outside consultant to address issues of team functioning. Team members need to be helped to focus on issues and behaviours rather than personalities and (imputed) motives.

Inspectors formed the opinion that the manager was doing all that could reasonably be expected of one person in relation to supervision. It is not realistic to expect that one manager can offer regular monthly supervision to 13 staff members. Part of the problem had to do with having large numbers of relief staff. The demands on the manager were such that she needed someone else to share the burden of management rather than just having someone to deputise for her in her absence. Clearly also, the manager needs some training and/ or guidance in relation to supervision. As part of this there needs to be some clarification of boundaries. The manager described all matters brought up in supervision as confidential to herself and the supervisee. This is appropriate to some issues. However, some staff members discussed issues of team functioning in supervision in the expectation that these would be brought to a team meeting. When this did not happen they concluded that their concerns were not receiving attention.

The staff team in AGLISH House was going through a very difficult time. This had to do with the communication difficulties referred to above. These were exacerbated by the considerable difficulties of caring for one particular client with special needs whose behaviour sometimes posed a risk to the safety of other young people and of staff members. In the six month period leading up to the inspection, three permanent staff members had to take time off as a result of stress or injury or both including one who had been out for over 3 months and was not due back until the beginning of next year. Senior managers were aware of the situation and WHB supported staff who took time off in such circumstances. Permanent staff were paid in full. Medical expenses were met. The board has paid for counselling. However, staff members who have had to take time off following an incident, with one exception, have not been paid the premium payments they would have been entitled to had they been at work as normal. In addition, it was not clear to relief staff members whether the supports offered by the board were available to all staff or only those employed on a permanent basis. Senior managers have endeavoured to offer other supports to the team at AGLISH. Money has been made available for extra staffing and for various team building events.

WHB is to be commended for many aspects of its approach to staff training and development. Senior managers were far from complacent about the difficulties in AGLISH. However, the solutions offered to the problems staff were experiencing were seen by staff as partial and incomplete. Staff were required to physically restrain one resident regularly but only a minority had been trained to do this safely and very few had had recent training in safe restraint. Staff had had no training specifically to do with caring for such a troubled child. Many staff members had become demoralised. They acknowledged that senior managers had put in extra supports. Nonetheless, they feared for their personal safety, for the safety of the other residents and felt that they had been left to cope with a situation that could only be sustained at great cost to themselves both personally and professionally. At the very least staff needed to know from senior managers how long they were expected to continue with the present arrangements. Consideration should be given to finding a consultant to help the staff manage and care for this particular young person for as long as it is envisaged he will

remain in Aglish. Finally, as suggested above, some work needs to be done with the team, preferably by an outside facilitator, to help them to come terms with the impact on the team members and on team functioning of the difficulties they are currently experiencing.

Recommendations:

- The WHB should increase the staffing complement in Aglish House so that there are sufficient permanent staff to cover all shifts with allowance built in for annual leave. One or two relief staff should be brought in as required to cover for staff who are ill or for other unforeseen absences
- The role of the houseparent should be clarified and expanded by the manager, principal social worker and child care manager so that she can assume some of the responsibilities currently carried by the manager.
- The manager and houseparent should, between them, ensure that all team members receive regular formal supervision.
- The principal social worker and / or child care manager should ensure that the manager and houseparent are given training and / or guidance on staff supervision.
- The general manager should clarify what supports are available to temporary staff members who are injured at work or who have to take time off due to work induced stress.
- The principal social worker and child care manager should indicate to staff in Aglish how long they are expected to care for the client with special needs.
- A staff facilitator should be engaged by WHB to help the team deal with issues of communication and team functioning.

4.6 Children's Rights

Aglish House and WHB generally are to be commended for the attention given to the issue of children's rights.

The WHB team leader for residential services is currently involved in the drawing up of a charter of rights for young people in care. At least one of the residents of Aglish House has been an active participant in this process.

4.6.1 Consultation

Young people's views are sought over key decisions which are likely to affect their daily life and future.

All young people in Aglish House, with the exception of the youngest resident, attended their reviews. They discussed with their social workers beforehand the issues that were likely to arise and completed a form for consideration at the review. The young people did, with some exceptions, convey to inspectors a sense that their wishes were taken into account. For instance, one young man objected to people attending his review that he did not consider sufficiently involved in his life to be included in making decisions affecting his future. The people in question were not invited to his next review. However, another young person felt that his views had not been taken into account in relation to who should attend his review.

Aglish House had a house meeting once per month. An agenda was posted some days before so that the young people could write down items for discussion as they occurred to them. The young people themselves were invited to chair and take minutes of the meeting. If no one volunteered, a staff member took the minutes. These were then brought to the staff meeting which fell on the day after the house meeting. Young people were able to give inspectors examples of things that they had brought to house meetings that had been acted on. They also complained about delays in getting action on some matters. These delays seemed to relate to problems in accessing funds rather than any unwillingness on the part of the staff to act on their suggestions.

4.6.2 Complaints procedure

Children in residential care need to be able to express their unhappiness or complain about their care.

WHB has recently developed a complaints policy and procedure for use in all children's residential centres, whether voluntary or health board run. This policy contains many exemplary features. It provides young people to be given a pre paid card addressed to a child care manager in another county requesting that contact be made with the young person. This is to deal with those situations where the young person experiences himself to be unsafe and cannot discuss this with those closely involved in his care. The policy document sets out various different stages at which a complaint can be addressed. If a complaint is incapable of resolution at one stage, it moves on to the next stage. Succeeding stages bring in personnel at more senior level within WHB and at greater remove from the unit in question. A limited independent, i.e. non WHB, involvement is provided for and, in the absence of resolution at any stage, complaints are referred to the Social Services Inspectorate. The Inspectorate does not, however, have a role in relation to investigating complaints.

This policy and procedure was poorly understood. Not all of the young people in Aglish had received their pre paid card and care staff, social workers and senior managers were unaware of the contents of the policy document. In the absence of a clear understanding of how the procedure was meant to operate, staff at Aglish and social workers described different ways of dealing with a complaint. All shared one element in common: they would report the matter to their line manager.

Inspectors formed the view that the complaints procedure is too elaborate. It is important to have a procedure that describes actions that will follow once a complaint is made. Otherwise, there is a danger that the procedure becomes a notification procedure only, that the matter is regarded as dealt with because someone in authority has been told about it. However, the procedure needs to be relatively simple, to be clearly understood by health board personnel and to be communicated to young people and parents.

Young people in Aglish House were able to identify a person they would go to if they were unhappy about something. This would usually be a keyworker, the manager and/ or their social worker.

One resident made a number of written complaints to the manager about being assaulted by another resident. She also made a detailed statement to her social worker about these assaults. This was recorded and passed on to the principal social worker. The matter was considered by the principal social worker and the manager. On advice from the principal social worker, the manager discussed the matter with the complainant and her mother. She acknowledged that the incidents complained of had occurred and were not acceptable. The manager was not able to assure the young person in any absolute way that the events complained of would not recur but she did express regret for what had happened and acknowledged the young person's right to complain.

It would, of course, be preferable to be able to ensure that the young person in question will not be assaulted again. However, as long as the young person who assaulted her remains in the unit this cannot be guaranteed. Steps were taken to improve the situation: extra staff were brought in and staff tried to ensure that the two young people concerned were not left alone at any time. The young person who made the complaint and her mother told inspectors they felt that staff had taken her complaint seriously and had acted on it. They had no sense of their views being disregarded.

4.6.3 *Access to information*

Young people are permitted access to significant sources of information about themselves and services available.

A brochure was produced for young people in Aglish House containing information about the house and its routines and about their rights and responsibilities. Young people in Aglish have found this information useful.

Young people were informed of and encouraged to participate in local clubs and activities. A number of the residents were involved in the local Neighbourhood Youth Project. Inspectors found evidence of discussions with young people about services that will be available to them in the future. One young man was able to tell inspectors that WHB will support him through college if he chooses to go on to third level education.

Young people in Aglish were given access to the individual daily logs written by staff about them. They were clear about their right to see such information. Sometimes the young people were invited to co-operate with staff in the writing of these logs. Inspectors commend this practice.

There was less clarity about whether or not the young people had a right to see those things that had been written about them by their social workers.

Recommendations:

- The team leader for residential services in WHB should revise the complaints procedure for residential units, in consultation with residential and child care managers. Each child care manager should take steps to ensure that whatever procedure is agreed is clearly understood by WHB personnel and explained to young people and their parents.
- The Mayo social worker department should develop a policy of sharing the information contained in case files with the young people in Aglish House. The young people should be informed of their right to see this information rather than the social work department awaiting their requests for access to such information.

4.7 *Child protection and safeguarding issues*

There are systems in place in the centre that aim to ensure that young people are protected from abuse. In particular, staff members are aware of, and implement, practices which are designed to safeguard young people in their care.

WHB has a policy and guidelines in relation to child protection for use in residential centres, a copy of which was contained in the Aglish House policy folder. It stated that the document should be read in conjunction with another board document on child protection and that all staff should be familiar with its contents. However, the other document referred to was not in the policy folder.

The document in the policy folder gave guidance on dealing with situations where it is suspected that a young person in a residential unit is or has been abused. Guidelines were also given on how to handle a disclosure of abuse. The names and phone numbers of key personnel were included. The guidelines were pertinent and helpful.

The policy folder also contained some suggestions for developing policies and guidelines in relation to safe care practices. However, these suggestions fell short of being fully developed policies. Despite this, staff members demonstrated an awareness of the need for safeguarding. Inspectors were made aware of situations where staff members were prepared to voice concern about the practices of colleagues. In one such situation this led to disciplinary action being taken against a member of staff.

In another situation a staff member expressed concern about the actions of another but was unsure whether her concerns were acted on by the manager. Inspectors are satisfied that they were acted on but suggested that the manager should ensure that staff members who raise concerns in this way are informed of the outcome. This creates a sense of confidence in the staff team that 'whistle blowing' is encouraged as a way of ensuring the safety of the young people in care.

In relation to the complaint referred to above, the matter concerned a very real risk to the safety of a young person in Aglish House. This young person had been assaulted by another resident on numerous occasions, 5 times in one 8 day period, and staff members said that they could not guarantee her safety. On one occasion the young person was sent home from Aglish House overnight for her own protection. This was despite the fact that she was admitted to Aglish because she was deemed to be unsafe

at home. The matter has been addressed as a complaint but not as a child protection issue. Senior managers expressed a concern about labelling a young person as an 'abuser'. While inspectors share this concern and accept that actions were taken on foot of this complaint the policy in relation to such issues is inadequate. Children First (10.5.2) states that where children abuse other children in residential centres, both victim and perpetrator should be dealt with under child protection procedures. Children First is not yet implemented. This is no reason for WHB to await its implementation to address the issue of the safety of young people in the board's residential centres.

Aglish House did not have a policy in relation to bullying. The need for such a policy was highlighted in the monitoring report prepared by the team leader for residential services in June 2000. Inspectors endorse this recommendation.

Recommendations:

- The manager of Aglish House should ensure the WHB guidelines on child protection are available to staff in Aglish House.
- The child care managers in WHB as the officers with overall responsibility for monitoring the child protection system should develop, in consultation with residential managers and the team leader for residential services, policies and guidelines to protect young people in care from assault by their peers.
- The manager and staff of Aglish House should develop their own anti bullying policy.

4.8 *Sanctions policy*

Each children's residential centre sets reasonable limits which everyone understands on what is regarding as acceptable behaviour and what is not. Sanctions generally work best in an environment where children are commended and rewarded for the achievement of good behaviour.

Written guidelines were available to staff on the use of sanctions. These guidelines very clearly set out what sanctions can be imposed and what is prohibited. Inspectors found they are followed in practice. The sanctions imposed are appropriate and moderate.

Good order in Aglish House is a function of the positive relationships between staff and young people. There is no excessive use of sanctions and young people made no complaints to inspectors in relation to this issue.

There is no separate sanctions book though sanctions are clearly recorded at the front of each young person's daily log book. Inspectors endorse the monitor's recommendation in relation to this matter that a separate sanctions book be kept and periodically reviewed by the manager.

Recommendation:

- The manager should keep a separate book for the recording of sanctions and review and sign it at regular intervals.

4.9 *Unauthorised absences of young people*

The centre takes steps to ensure that young people who absent themselves from the centre without consent are protected in line with written policy and guidance.

The policy and procedures folder in Aglish contained a section on unauthorised absences which set out what staff members must do in the event of a young person being absent without permission or not returning to the unit at the agreed time.

Unauthorised absences that exceed one hour are recorded on incident forms and these are kept in the young person's file and in an incidents file. Staff members must inform Gardai, social worker and parent/s.

In a one year period to October 2000 there were 25 unauthorised absences. All of these involved 2 young people who are no longer resident in Aglish. Unauthorised absence was not an issue of concern with the client group in Aglish at the time of inspection.

4.10 *Ethos and quality of care*

4.10.1 *Living skills*

The acquisition of living skills is an integral part of the care process and should be individually tailored to meet the needs of each child in a structured and planned way. The care experience provides children with the skills, competencies and knowledge necessary for adulthood and citizenship.

The older residents of Aglish were encouraged to exercise age appropriate responsibility in relation to various day to day tasks. The young people worked out a rota between them for cleaning up after meals. Staff reported that this worked better than an adult imposed regime.

Young people went shopping for groceries with staff members. When it came to buying clothes either they went alone or with a staff member.

There were two obstacles to the development of living skills. Aglish House had an account in the local supermarket. When goods were purchased staff had to go to a till separate from other shoppers and announce themselves as being from Aglish House. This immediately identified those concerned as different from other shoppers. The young people complained to inspectors about the stigmatising impact of this. It acted as a disincentive to the young people to participation in the shopping.

Staff members were also required to use requisition forms for the purchase of various items. The manager avoided the use of these forms when shopping for clothes for the young people but other items were purchased in this way. This again set those involved apart from others.

The use of accounts and requisition forms is unacceptable. Shopping should be undertaken in a way which does not identify the young people as being in care.

4.10.2 Psychological and emotional development

The emotional life of young people in care is given special attention. Young people know that there is a responsible adult available who is capable of understanding them, and as such, is a real source of confidence and support for them.

Each young person had a keyworker, one young person had two. Keyworkers described their role in terms of being a link person and advocate for the young person in question and as being the person who arranged various aspects of the young person's care: home visits, appointments with other professionals etc

The youngest resident was assessed by two professionals from another health board who concluded that he had an attachment disorder. Under a recently implemented programme, his two keyworkers worked at different times of the day to ensure that he had access to one or the other during most of his waking hours.

There were aspects of the care of this child that gave rise to some concerns. In Aglish House the kitchen and living room are joined. During inspection, the television was constantly on, even during meals, and it seemed that staff were using it as a way of distracting the child from undesirable behaviour. Also sweets, crisps and lollipops were used as incentives to good behaviour. At the best of times this does not constitute good practice but it is particularly unfortunate in light of the fact that the child in question was overweight. Staff members freely acknowledged that this was not as it should be but were at a loss to know how else to deal with him. These kind of practices and the fact that staff had sometimes been powerless to prevent this child assaulting other young people had had a demoralising effect on staff members and led to a sense that their own professional practice had been compromised.

Despite the fact that the keyworkers for this child were offering him intensive support involving a high degree of their availability, the child still had to cope with the fact that there were 12 other staff involved in his care. This is hardly conducive to addressing his attachment difficulties. Inspectors were informed that having a lot of people around this child can lead to his behaviour becoming more rather than less difficult to manage. Staff members also acknowledged that, at other times, having extra staff around helped to keep the other young people safe. Several people questioned whether this child was happy in Aglish.

The needs of this boy were of a different order to the needs of the other young people in Aglish. This gave rise to certain tensions and a belief on the part of staff members that the older residents missed out on receiving the quality of care that they deserve and that staff wished to provide for them. Due to the need to provide intensive support to the youngest resident, staff believed that they lacked the time and energy to attend to the needs of the older residents.

The young people did not express any sense of being neglected to inspectors. They spoke positively about staff members and expressed a willingness to confide in at least some of them. They could see that staff were making efforts to compensate for the amount of time devoted to the youngest resident and appreciated these. For instance, they commented favourably on a new initiative to take them out for a meal at least once per month.

Although staff were caring in their approach it was clear they were constrained from meeting the needs of all residents as fully as they would have wished because of the distraction caused by one resident whose behaviour was constantly challenging.

4.10.3 Preparation for leaving care

Young people are adequately prepared for when they leave care, equipped with the skills knowledge and resources, which they will require.

There were no structured programmes in place in relation to preparation for leaving care at the time of inspection. The social worker for one resident said that such a programme will be worked out for him shortly as it seems clear that he will not return home. The social worker will continue to work with him after his 18th birthday. This young man was clear that the health board will support him through college.

Senior managers informed inspectors that WHB policy is to provide support to care leavers up to their early 20s whether or not they are still in full time education. This is to be commended.

4.10.4 Physical aspects of the residential centre

Young people experience their living environment as similar in terms of furnishings and facilities to the homes of their peers.

The premises at Aglish House were not attractive and not well maintained. Inspectors observed broken tiles, broken shelves, broken glass in the garden and garage. There were aspects of the grounds that appeared to inspectors to be at least potentially hazardous. There was a barbed wire fence at the bottom of the garden. Two rusty poles that supported a washing line were leaning to one side. They were not secured into the ground and could fall over causing possible injury. There were large cracks in the wall between Aglish and the house next door.

Overall the impression conveyed was dismal and uninviting and reflected poorly on WHB. While the building was due to be sold soon and a new unit built it was apparent that certain parts of the building had not been redecorated for a long time.

The manager reported difficulty in getting routine repairs and maintenance done.

4.10.5 Respect of child's privacy, dignity and individuality

The unique worth and individuality of each child should be valued and reflected in the ethos, management and care practices of each centre. Children's quality of life will be influenced by the value placed on their dignity and individuality in all aspects of daily life

Aglish House had a policy of respecting the privacy, dignity and individuality of each young person. The young people had keys to their own rooms which were hung from a nail high up and out of reach of the youngest resident. This was an acceptable and creative solution to a problem of this child bursting into other young people's rooms.

Staff members were expected to knock and wait to be invited before going into a young person's room. While this was generally respected in practice, two young people told inspectors of a staff member who had entered their rooms without waiting to be invited. This matter was recently brought to the attention of the manager by one of the young people concerned. Inspectors are confident that the matter will be dealt with appropriately.

Staff members were sensitive to the feelings of the young people in relation to their care status. At the suggestion of the young people the office phone was left in the hall after 5pm so that anyone could answer it. It was agreed that whoever did answer would not announce to the caller that they had reached Aglish House.

Having the house phone in the hall placed restrictions on the amount of privacy young people were able to have when making calls. On the other hand, letters to the young people were handed over to them unopened.

4.10.6 Education

Each child has a right to education, which should be seen as a significant issue affecting the welfare of the child. The residential setting should be one in which education is valued, children's educational needs are actively addressed and each child is encouraged to attain his/her full potential. This will involve liaison with the health board social worker, schools and other appropriate training and educational bodies.

Two of the current residents were in school, one was attending Youthreach. The youngest resident was not attending school though a place in a special school was being actively sought for him. Young people were actively encouraged and supported to pursue education and training. The young people had desks in their rooms to facilitate them doing their homework. Inspectors observed young people being encouraged to do their homework. During the course of the inspection a young person attended a meeting at his training centre with his keyworker to help him overcome problems he was experiencing there. These difficulties were overcome and the young person resumed his training programme.

One resident who was admitted from a nearby town was facilitated in continuing to attend her original school through the provision of daily transport. Inspectors commend this far sighted practice.

4.10.7 Health Care

The provision of appropriate health care and advice is acknowledged as an essential element in the arrangements for the care of young people in the centre.

The health care needs of each resident were considered at every review. Where possible young people continued to attend the GP they attended prior to placement in Aglish. Where this was not possible, a local GP was used. There was a great deal of liaison between medical personnel, Aglish staff and the social work team in relation to the health care needs of the youngest resident.

Staff availed of opportunities to discuss with young people issues such as smoking and drinking. There was no smoking allowed in the house. Some of the young people smoked in the back yard.

Staff members stated an openness to answering any questions put to them in relation to sexuality, provided that the questions were ones designed to elicit information or advice rather than to embarrass staff. There were no structured programmes in relation to sexuality, relationships, self care etc.

The diet in Aglish was varied and nutritious. Supplies of fresh fruit and vegetables were in evidence. Young people were free to make tea, take food from the fridge or from the fruit bowl. All of this is very commendable. However, closer attention needs to be given to the diet of the youngest resident.

Recommendations:

- The general manager should immediately ensure that Aglish House no longer has to use requisition forms or has to make purchases on account in the local supermarket.
- Social Workers, in drawing up care plans, should include a section on preparation for leaving care.
- The principal social worker and child care manager should give consideration to making some special arrangement for the care of the youngest resident in Aglish House. This should involve his current keyworkers, if at all possible.
- The general manager should ensure that the premises at Aglish House are decorated and maintained to a standard one would expect of an ordinary family home.
- The manager should reinforce the boundaries around the privacy of the young people's bedrooms with the staff team.
- The general manager should sanction the purchase of a cordless phone so that young people can make and accept telephone calls in privacy.
- The young people's social workers, in drawing up their care plans, should address the issue of their need for information and advice in matters of health, personal relationships and sexuality.

4.11 Administration

4.11.1 Fire precautions

The centre takes positive steps to keep children safe from the inherent risk of fire and other hazards to an extent that is consistent with Regulation 12 of the Child Care Regulations, 1995.

There were 6 fire extinguishers around the building and an extinguisher and fire blanket in the kitchen in Aglish House. Fire escape routes were clearly marked and were unencumbered. There were smoke detectors in bedrooms, offices, store rooms, hall, landing and in all the other living areas. An automatic fire alarm system was fitted.

There was evidence of the fire extinguishers having been checked but no maintenance record of the fire alarm system.

Fire drills were carried out in Aglish on a monthly basis and the details recorded.

Following inspection inspectors received a copy of a letter, dated December 1st, 2000 and signed by board's fire and safety officer. He referred in this letter to an earlier letter, of May 21st, 1998, where he recommended 10 measures to bring fire protection in Aglish House up to an acceptable standard. Inspectors were most concerned to learn that, two and a half years later, 4 of these matters which relate to means of escape and emergency lighting remain outstanding. This is in direct contravention of the Child Care Regulations (1995), Section 12. This issue must be attended to as a matter of urgency.

4.11.2 Insurance

Each children's residential centre should be adequately insured against accidents or injury to children placed in the centre.

Aglish House is insured under WHB's insurance policies.

4.11.3 Young people's records

Each young person has a permanent, private and secure record of their history and progress which may, where in compliance with legal requirements for safeguards, be seen by the young person and by the young person's parents as appropriate.

Each young person had their own case file in Aglish House and, as stated, the young people were informed of their right to see anything written about them by Aglish House staff. These files were kept locked in a filing cabinet in the manager's office.

One case file was a model of clarity and accessibility of information but others appeared to be put together haphazardly. Key workers are urged to follow the good example set by their colleague and divide up the case files with discrete sections for care planning and review, education, health and so on. All case files should have a

summary sheet at the front to allow for ease of access to essential information such as names and addresses of family members, social worker and significant others, access arrangements, special health needs, care status and so on. In addition all files must have copies of birth certificates, admission to care forms and, where appropriate, a form, signed by the young person's parent, giving consent to medical treatment for their child.

4.11.4 *Administrative records*

Administrative records contain all significant information, decisions and actions relevant to the effective running of the centre.

The administrative records in Aglish House were maintained to a high standard.

4.11.5 *Safety*

Each children's residential centre has adequate arrangements in existence to guard against the risk of injury occurring on the premises, in accordance with Article 13 of the Child Care Regulations, 1995.

A health and safety statement was prepared for Aglish House in 1997. A copy was contained in the policies and procedures folder. Each member of staff was expected to read the statement and sign a form to confirm that they had done so. There was, however, only one signature on this form.

Inspectors were made aware of a safety concern arising from the layout of the building. The staff sleep-over room is on a corridor on the lower ground floor and in order to contact the staff member on sleep over the night supervisor must use the phone on the ground floor. This phone is in the office. The night supervisor was assaulted recently while the other staff member was still asleep. By her account, it took 20 minutes for her to reach the phone to alert her colleague. The night supervisor was concussed as a result of this assault. It was a matter of good fortune that she was able to reach the phone at all.

A system needs to be put in place that allows staff in different parts of the building to communicate easily with each other easily.

The safety statement needs to be updated generally and to take specific account of this issue and that of safe exit from the lower ground floor in the event of fire.

4.11.6 *Maintenance of Register*

Information on individual children who are admitted to a residential care centre is recorded in a Register, maintained by a health board, under Section 21, Part IV of the Child Care (Placement of children in Residential Care) Regulations 1995. Such information is updated as changes occur and includes information on the circumstances and the date on which a child is discharged.

The register of children in care in Mayo is maintained by WHB at Hill House, the headquarters of the social work department.

4.11.7 *Supervision and visiting of young people*

Visiting of young people in Aglish by their social workers exceeds the expectations laid down in the child care regulations.

4.11.8 *Monitoring of standards*

The centre has adequate arrangements in place to enable an authorised person, on behalf of the health board, to enter and inspect the centre in compliance with Article 17 of the Child Care Regulations, 1995.

Monitoring of standards in Aglish House is done by the team leader for residential services for WHB. His report, completed in June of this year was made available to inspectors. This report complies with the regulations and proved an invaluable aid to inspectors.

Recommendations:

- The general manager must, as a matter of the utmost urgency, attend to the matters raised by WHB's fire and safety officer in relation to fire protection in Aglish House.
- The general manager should arrange for the health and safety statement at Aglish to be updated.
- The manager of Aglish House should ensure that staff are familiar with the contents of the safety statement and require them to sign to confirm that they have read it.
- The general manager should ensure that there is a communication system within Aglish House that allows staff in different parts of the building to communicate easily with each other.
- The manager should ensure that the young person's files are maintained in a manner that allows for ease of access to information.

Physical restraint is never used as a punishment, but only to protect from immediate risk of injury or serious damage to property. The Health Board has a policy on the use of physical restraint that is clearly understood by all staff and young people in the centre.

There is no separate policy in Aglish House on the use of physical restraint.

In the last 6 months physical restraint has only been used with one resident of Aglish House and he was restrained 8 times between May 25th and October 18th. Five of these restraints occurred in a 5 week period between the middle of September and the middle of October. Staff were exercising this form on control with increasing frequency.

Only a minority of staff had received training in safe forms of physical restraint and, of these, most were trained some years ago.

If, as seems apparent, physical restraint is part of what staff in Aglish are required to do from time to time then they must be given training in it and their actions must be guided by policies and practice guidelines.

Recommendations:

- The manager, in consultation with staff, should develop a policy in relation to the use of physical restraint and monitor its implementation.
- The manager should ensure that all staff members are trained in the safe use of physical restraint and the child care manager should ensure that the necessary resources are made available.

5. Summary of recommendations

1. The statement of purpose and function needs to be revised by the manager in consultation with her line manager and the child care manager. The statement should reflect the fact that Aglish House offers medium to long term residential care for children and young people and will admit them on an emergency basis in particular circumstances.
2. The principal social worker and child care manager must ensure that children and young people are not placed inappropriately and that, where an inappropriate placement is all that is available in an emergency, the young person so placed is moved to a more appropriate placement as soon as practicable.
3. WHB needs to ensure that all the professional resources at its disposal are available to meet the needs of the children in its care.
4. The admissions policy needs to be revised by the manager to take account of both planned and unplanned admissions. The circumstances in which young people can be admitted without prior referral to the admissions panel need to be clarified.
5. The admissions policy, thus modified, needs to be communicated by the principal social worker to those who may wish to make referrals. In particular, the Gardai need to be informed of this policy, given that they have referred a young person to Aglish House in the past.
6. The principal social worker should ensure that care plans for the young people in Aglish House are completed on the standard WHB care plan form and that they are signed and dated by the social worker with case responsibility for the young person.
7. The WHB should develop a standard care plan review form in line with the standard care plan form to ensure that reviews refer to care plan aims and objectives, assess their implementation and set targets for completion before the next review.
8. Suitable facilities should be provided for family members who visit Aglish and senior managers should ensure that these are included in plans for the new purpose built unit to replace the present premises.
9. The WHB should increase the staffing complement in Aglish House so that there are sufficient permanent staff to cover all shifts with allowance built in for annual leave. One or two relief staff should be brought in as required to cover for staff who are ill or for other unforeseen absences
10. The role of the houseparent should be clarified and expanded by the manager, principal social worker and child care manager so that she can assume some of the responsibilities currently carried by the manager.
11. The manager and houseparent should, between them, ensure that all team members receive regular formal supervision.
12. The principal social worker and / or child care manager should ensure that the manager and houseparent are given training and / or guidance on staff supervision.

13. The general manager should clarify what supports are available to temporary staff members who are injured at work or who may have to take time off due to work induced stress.
14. The principal social worker and child care manager should indicate to staff in Aglish how long they are expected to care for the client with special needs.
15. A staff facilitator should be engaged by WHB to help the team deal with issues of communication and team functioning.
16. The team leader for residential services in WHB should revise the complaints procedure for residential units, in consultation with residential and child care managers. Each child care manager should take steps to ensure that whatever procedure is agreed is clearly understood by WHB personnel and explained to young people and their parents.
17. The Mayo social worker department should develop a policy of sharing the information contained in case files with the young people in Aglish House. The young people should be informed of their right to see this information rather than the social work department awaiting their requests for such access.
18. The manager of Aglish House should ensure the WHB guidelines on child protection are available to staff in Aglish House.
19. The child care managers in WHB as the officers with overall responsibility for monitoring the child protection system should develop, in consultation with residential managers and the team leader for residential services, policies and guidelines to protect young people in care from assault by their peers.
20. The manager and staff of Aglish House should develop their own anti bullying policy.
21. The manager should keep a separate book for the recording of sanctions and review and sign it at regular intervals.
22. The general manager should immediately ensure that Aglish House no longer has to use requisition forms or has to make purchases on account in the local supermarket.
23. Social Workers, in drawing up care plans, should include a section on preparation for leaving care.
24. The principal social worker and child care manager should give consideration to making some special arrangement for the care of the youngest resident in Aglish House. This should involve his current keyworkers, if at all possible.
25. The general manager should ensure that the premises at Aglish House are decorated and maintained to a standard one would expect of an ordinary family home.
26. The manager should reinforce the boundaries around the privacy of the young people's bedrooms with the staff team.
27. The general manager should sanction the purchase of a cordless phone so that young people can make and accept telephone calls in privacy.
28. The young people's social workers, in drawing up their care plans, should address the issue of their need for information and advice in matters of health, personal relationships and sexuality.

29. The general manager must, as a matter of the utmost urgency, attend to the matters raised by WHB's fire and safety officer in relation to fire protection in Aglish House.
30. The general manager should arrange for the health and safety statement at Aglish to be updated.
31. The manager of Aglish House should ensure that staff are familiar with the contents of the safety statement and require them to sign to confirm that they have read it.
32. The general manager should ensure that there is a communication system within Aglish House that allows staff in different parts of the building to communicate easily with each other.
33. The manager should ensure that the young person's files are maintained in a manner that allows for ease of access to information.
34. The manager, in consultation with staff, should develop a policy in relation to the use of physical restraint and monitor its implementation.
35. The manager should ensure that all staff members are trained in the safe use of physical restraint and the child care manager should ensure that the necessary resources are made available.