



**Health
Information
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An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

**Social Services
Inspectorate**

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE DUBLIN NORTH EAST

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ADDRESS: Health Information & Quality Authority, Social Services Inspectorate,
3rd Floor, Morrison Chambers,
32 Nassau Street, Dublin 2

PHONE: 01-604 1780 FAX: 01-604 1799

WEB: www.hiqa.ie/functions_ssi.asp

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1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a high support unit in the Health Services Executive (HSE), Dublin North East Area (DNE) under Section 69 (2) of the Child Care Act 1991. Mary Tallon, inspector manager carried out the inspection over a two day period, 29th to 30th of January, 2008.

The campus style unit was located on the grounds of a large psychiatric hospital. The campus comprises three accommodation units, an administration block, a school and a gymnasium. It is enclosed by a perimeter fence with a central green area and can only be accessed via the administration block. This is staffed on a 24 hour basis. The individual accommodation units are locked from the outside during the day and young people can open the doors from the inside and leave if they wish. After 8pm the doors are locked on both sides and it is not possible to leave without permission.

The stated purpose and function of the unit is to offer high support care to 16 young people of mixed gender aged from twelve to seventeen years. The inspector was told that due to current staffing levels the maximum number of young people it could provide care for was 12. At the time of inspection there were six young people resident, four boys and two girls aged 13 to 16 years, three in each unit. Another young person was in transition to the unit and there was plans for her to stay overnight in the days following inspection.

1.1 Methodology

This inspection was carried out against *the National Standards for Children's Residential Centres, 2001* with particular focus on the following three standards;

- | | |
|-------------|---|
| Standard 5: | planning for children and young people, |
| Standard 6: | care of young people |
| | <i>and</i> |
| Standard 7: | safeguarding and child protection. |

The inspection was carried out in conjunction with the *Child Care (Placement of Children in Residential Care) regulations 1995*. In this inspection, the inspector judgements' was based on analysis of findings verified from several sources of evidence gathered through interviews with HSE staff members and management, observations of interactions between young people and staff, talking with some of the young people, examination of relevant records and documentation and an inspection of accommodation.

The inspector had access to the following documents during the inspection: the centre's statement of purpose and function, policies and procedures, the young people's care files and census forms, child protection documentation, details of unauthorised absences and physical restraints, census forms on management and staff, administrative records, health and safety records and confirmation of insurance.

In the course of fieldwork the inspector interviewed the deputy director, a unit manager, the monitoring officer, and attended a serious incident review group meeting. The inspector was introduced to four of the young people and spoke briefly to them in a group. Following the inspection fieldwork the inspector met with the director to provide feedback on inspection findings.

1.2 Acknowledgements

Inspectors acknowledge and appreciate the co-operation of the young people, HSE management and staff and the Co-ordinator of the Mater Support Team, who participated in the inspection.

1.3 Management structure

The centre was managed by a director and a deputy director. Since the last inspection the line management structure had changed and the director now reported to the national director with responsibility for special care and high support units.

1.4 Data on young people

On the first day of fieldwork the following young people were residing in the unit:

Listed in order of length of placement

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
# 1 (girl)	15	Voluntary Care	Eight months	Eight residential placements, three foster placements,
# 2 (girl)	15	Voluntary Care	Six months	Five residential placements
# 3 (boy)	14	Voluntary Care	Five months	Three residential placements, one foster placement.
# 4 (boy)	14	Voluntary Care	Three months	Ten residential placements, five foster placements.
# 5 (boy)	13	Voluntary Care	Two months	Eight foster placements, two residential placements.
# 6 (boy)	15½	Care Order	Two months	Five residential placements, one hospital placement.

* At the time of inspection staff were involved with another young girl, preparing her for admission to the unit.

2. Analysis of Findings

The unit had previously been inspected by the SSI in June 2005 with a follow up inspection in 2006. As a high support unit currently caring for 6 young people, the unit cares for young people that present with complex needs and challenging behaviour. The inspector was concerned to find that issues identified in 2005 and 2006, regarding the management of behaviour and safety, were found to be present on this inspection. The issues related to violent, aggressive and risky behaviours of some young people. These behaviours had been present for some months, and had not decreased despite management and staff efforts to try different strategies to respond to these behaviours. There had been a significant increase in the unauthorised absences by young people and the use of physical restraint by staff in managing the behaviour of one young person. The inspector was concerned that managers and staff had not succeeded in improving this situation over the past months. Overall, the inspector was of the view that the unit was not meeting the challenging needs of the young people despite adequate resources.

Practices that met the required standard

Since the last inspection the management and staff had made good efforts to address supervision of care staff, to review the policies, procedures and practice in relation to complaints, child protection concerns and systems to review and address behaviour management issues in the unit.

Consultation

The inspectors saw evidence that the young people read accounts of their day. They were invited to attend all meetings at which decisions were made about them and the majority of them did attend. They each had their own room which they personalised with posters and personal memorabilia. One of the young people had small pets which he looked after. They had choices in terms of food, clothing and outings and had opportunities to select their favourite dinner on a weekly basis.

Qualifications

The HSEDNE had a policy of supporting staff in obtaining a formal qualification and at the time of inspection there were six staff at various stages of professional social care training. The inspector found that a significant number of staff have yet to receive formal professional training and recommends the continued support and development of strategies by management to increase the number of qualified staff.

Individual work

The inspector noted some good examples of key working and placement plans with the young people.

Vetting

In general the standard of vetting was good with staff having garda clearance and the required three references. The inspector was told that the unit use two agencies which are contracted by the HSEDNE to provide for the provision of staff to residential care services. The inspector was told that when agency staff commence employment in emergencies or at short notice the unit management does not have access to copies of their garda clearance and references. Vetting of staff should be supported by a rigorous system of evaluation and verification of references and the inspector recommends that

HSE senior management satisfy themselves the vetting procedures for agency staff are monitored and reviewed on a regular basis.

Recording

The young people's care files contained all relevant documentation in an accessible format. The standard of record keeping and filing was good.

Register

The centre had a register that was maintained in accordance with the regulations.

Practices that met the required standard in some respect only

Management & Staffing

The staff team comprised the director, deputy director, forty six social care staff, two domestic staff, two chefs and three administrative staff. At the time of inspection the staff worked in teams of twenty with a unit manager and deputy in each accommodation unit. They provided the necessary cover for the roster which included sick leave, annual leave or training. The current roster allowed for four staff during the day and three waking staff at night to care for three young people. In addition in the weeks prior to inspection a decision had been made to have an increased ratio of staff for one young person. Given this high ratio of staff to young people and the ongoing difficulties in the unit, the inspector recommends that the deployment of staff is reviewed to ensure it best meets the needs of the young people and effective management practices.

Access to specialist services

The Mater Support Team, which is part of the Mater Hospital Child and Adolescent Mental Health Team, provided a support service to the unit. This team comprised a systemic psychotherapist and team coordinator, a speech and language therapist, consultant child and adolescent psychiatrist and a psychologist. This team were located in offices on the campus two and half days a week and the psychiatrist was available one day a week. They attended weekly staff meetings, review and planning meetings providing guidance, support and a range of assessments and therapeutic interventions. In response to recommendations of the previous inspection they introduced "well being assessments" which involved an assessment of young people who had experienced or witnessed a restraint, The inspector was concerned to find recordings where staff described their confusion in how to respond to a young person who had self harmed. The inspector recommends that staff receive consistent direction and guidance in responding to young people who self harm. In view of the current number of young people resident in the centre and due in part to their limited engagement with the range of resources made available to them, the inspector recommends that the HSE and clinical specialist team review specialist resources to ensure that the best use is made of them.

Monitoring

The monitoring officer received notifications of unauthorised absences, use of physical restraints, significant events and incidents. He attended the serious incident review group in the weeks prior to inspection and had frequent phone contact with the deputy director on different matters relating to the operation of the unit. He had scheduled an audit visit of the unit in the week following inspection. The monitoring officer has an important safeguarding function. However, inspectors were concerned that there was no written report of monitoring over the previous year. Inspectors recommend that there are frequent visits by a monitoring officer followed by a monitoring report outlining

compliance with standards, in particular on safety and welfare of the young people. This report should be copied to the Social Services Inspectorate.

Care planning

Whilst all young people had care plans, the inspector was of the view that the quality of the care plans was not satisfactory. The majority of young people had experienced a significant number of previous care placements prior to admission to the unit. Despite many regular meetings, the inspector found little evidence of planning for the young people's future. Inspectors recommend that care plans are reviewed immediately in consultation with the young people and direct onward placements as required by the standards in preparation for leaving care.

Child Protection

Since the last inspection the unit had made great efforts to put comprehensive child protection systems in place and all concerns or allegations of abuse were formally notified in accordance with Children First and agreed local procedures. Whilst all relevant personnel were notified of significant events or incidents there was not a prompt, timely or comprehensive response to the seriousness of the incidents. Whilst the inspector found evidence of child protection concerns that had been notified and an appropriate response was made by the unit, at the time of inspection some of these concerns had not been concluded and allegations made by one young person had not formally been addressed with him. The inspector also considered that other issues, such as bullying behaviour, was not dealt with comprehensively.

Education

The on site school provides an educational service to all of the young people in the unit and from time to time to non-resident young people. However, the inspector was told that most of the young people were not attending school or training on a consistent basis. Staff described challenges in getting the young people up in the morning to attend class or training courses. The inspector found that one young person who was referred to the unit because of his challenging behaviours and non school placement three years prior to inspection, and other young people who had experienced difficulties in accessing and attending school or training consistently, had either attended school sporadically or had not attended an identified training course in the months prior to inspection. The inspector considered that this matter was directly related to the behaviour management issues in the unit. An urgent review of the strategies used to manage regular attendance at school or training is recommended.

Health

The inspector was concerned that some of the young people were frequently drinking and or taking illicit harmful substances when out of the centre, (313 unauthorised absences in the year prior to inspection). At the time of inspection the inspector found no evidence that young people were actively participating in programmes to address these issues or measures to prevent them engaging in at risk behaviours. Some of the young people were placing themselves at risk and the inspector was concerned that there was a particular need for urgent practical advice and guidance in areas of teenage health issues. One of the young people who had particular medical and health needs had not yet attended a hospital to get the relevant support and attention they required.

Fire safety

The inspector found evidence of fire safety concerns where young people were smoking in their bedrooms; one young person had attempted to light a fire in the unit and had

also attempted to set fire to the unit vehicle. The inspector was told that the fire officer had not completed an audit of the unit in the year prior to inspection. The inspector recommends that these issues are attended to and there are clear procedures in the event of an emergency which are in accordance with standard 10.21.

Practices that did not meet the required standard

The standards on the management of behaviour and safeguarding were not met.

Management of behaviour

The inspector had serious concerns about the effectiveness of the management of behaviour in the unit and considered that whilst efforts were made to address challenging behaviours, there was little evidence of effective strategies. The inspector found evidence of serious violent and aggressive behaviours, a significant increase in unauthorised absences from the unit, an increase in the use of physical restraint, and an inappropriate reliance on the Gardai to assist in managing the behaviour of some of the young people. Inspector found evidence of staff turning off the electric power supply to the young people's rooms in an attempt to get them to behave and go to sleep. Whilst staff had endeavoured to implement an appropriate sanctions system, rewarding good behaviour and giving appropriate sanctions for negative behaviours, they had difficulties in establishing appropriate measures to reduce serious risk behaviours exhibited by the young people.

- *Violent and aggressive behaviours*
In the months prior to inspection the inspector was told that at least 5 staff had been injured by young people in the unit. In the year prior to inspection the Gardai were called to the unit on 19 occasions to manage difficult and violent behaviours. Physical restraint was used on 17 occasions in one month with one young person. Following a recommendation of the previous inspection, the use of physical restraint was reviewed by the unit and a critical incident review group was established to look at the use of physical restraints. The inspector was concerned that despite this review there was no rigorous evaluation of the effectiveness of the use of physical restraint in relation to one young person.
- *Unauthorised absences*
The inspector found 313 absences without authority in the year prior to inspection. One young person had been absent without permission for more than three weeks in the months prior to inspection. Some young people left the unit daily to engage in activities that put themselves or others at risk. Whilst the unit attended meticulously in following the protocol following such incidents this had not impacted on the level of absences or changed the outcomes for the young people.
- *Daily routines*
There was a lack of purpose and direction to the young people's daily routines. The inspector was concerned that the young people were managing their own routines, in some instances leaving the unit daily and not returning until early the following morning. Young people were not attending school or training on a consistent basis and one young person had not attended a training course external to the unit since their admission.

Safeguarding

The inspector found that standard on safeguarding was not met from the evidence above on the management of behaviour. The inspector was of the view that supervising social workers and line management could not satisfy themselves that the young people were safe and well cared for.

Conclusion

Despite the effort of management and staff, key standards are not met. The purpose of the unit is to care for challenging young people, unfortunately at this time this was not evident. The inspector recommends that HSEDNE takes appropriate action to rectify the situation as a matter of urgency.

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	Not inspected		

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		√	
Supervision and support		√	
Training and development	√		
Administrative files	√		

Recommendations:

1. The HSE Dublin North East should review the deployment of staff to ensure it best meets the needs of the young people at all times.
2. The HSE Dublin North East should ensure that external line management monitor practice and evaluate its effectiveness on the welfare of young people on a continuous basis.

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		√	

Recommendation:

- The HSE Dublin North East should ensure that the unit is monitored regularly and that monitoring reports comment on the safety and welfare of young people.

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	Not inspected		

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	Not inspected		
Statutory care planning and review		√	
Contact with families	Not inspected		
Supervision and visiting of young people	Not inspected		
Social work role	Not inspected		
Emotional and specialist support		√	
Preparation for leaving care		√	
Aftercare	Not inspected		

Recommendations:

4. The HSE Dublin North East should ensure that care plans direct onward placements and are reviewed immediately in consultation with the young people as required by the standards in preparation for leaving care.
5. The HSE Dublin North East should ensure that staff receive direction and guidance in responding to young people who self harm.
6. The HSE Dublin North East and the clinical specialist team should review specialist resources to ensure they are effectively deployed.
7. The HSE Dublin North East should ensure that all supervising social workers read centre records from time to time, visit and meet with young people in response to notification of unauthorised absences, use of physical restraints and significant events.

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	Not inspected		
Provision of food and cooking facilities	Not inspected		
Race, culture, religion, gender and disability	Not inspected		
Managing behaviour			√
Restraint			√
Absence without authority			√

Recommendation:

- The HSE Dublin North East should revise, as a matter of urgency, the behaviour management strategies in the unit including the daily routines of the young people.

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:

- The HSE Dublin North East should, as a matter of priority, revise current safeguarding practice.
- The HSE Dublin North East should ensure that external line managers monitor and evaluate safeguarding practices in the centre regularly.

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:

11. The HSE Dublin North East should review their strategy to encourage all young people to attend school or training consistently.

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		√	

Recommendation:

12. The HSE Dublin North East should ensure that young people access essential medical and health services as required and that there is an ongoing programme available for the young people on teenage sexual health and relationship 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	Not inspected		
Maintenance and repairs	Not inspected		
Safety		√	
Fire safety		√	

Recommendation:

13. The HSE Dublin North East should ensure that fire safety issues are responded to in accordance with standard 10.21.

4. Summary of recommendations

1. The HSE Dublin North East should review the deployment of staff to ensure it best meets the needs of the young people at all times.
2. The HSE Dublin North East should ensure that external line management monitor practice and evaluate its effectiveness on the welfare of young people on a continuous basis.
3. The HSE Dublin North East should ensure that the unit is monitored regularly and that monitoring reports comment on the safety and welfare of young people.
4. The HSE Dublin North East should ensure that care plans direct onward placements and are reviewed immediately in consultation with the young people as required by the standards in preparation for leaving care.
5. The HSE Dublin North East should ensure that staff receive direction and guidance in responding to young people who self harm.
6. The HSE Dublin North East and the clinical specialist team should review the use of specialist resources to ensure they are effectively deployed.
7. The HSE Dublin North East should ensure that all supervising social workers read centre records from time to time, visit and meet with young people in response to notification of unauthorised absences, use of physical restraints and significant events.
8. The HSE Dublin North East should revise, as a matter of urgency, the behaviour management strategies in the unit including the daily routines of the young people.
9. The HSE Dublin North East should, as a matter of priority, revise current safeguarding practice.
10. The HSE Dublin North East should ensure that external line managers monitor and evaluate safeguarding practices in the centre regularly.
11. The HSE Dublin North East should review their strategy to encourage all young people to attend school or training consistently.
12. The HSE Dublin North East should ensure that young people access essential medical and health services as required and that there is an ongoing programme available for the young people on teenage sexual health and relationship issues.
13. The HSE Dublin North East should ensure that fire safety issues are responded to in accordance with standard 10.21.