



**SOCIAL SERVICES  
INSPECTORATE**

**CRANNOG NUA HIGH SUPPORT UNIT  
NORTHERN AREA HEALTH BOARD**

**INSPECTION REPORT ID NUMBER: 87**

**Publication Date: 17 Dec 2003  
SSI Inspection Period: 5  
Centre ID Number: 257**

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## **2. Executive summary**

The inspection of Crannog Nua High Support Unit was carried out by the Social Services Inspectorate between 9<sup>th</sup> – 11<sup>th</sup> September 2003. This section provides a summary of the main findings of the inspection. Readers wishing a more detailed account should refer to the main sections of the report.

Crannog Nua High Support Unit was established in August 2002 in north Co. Dublin. It is based in a large purpose built facility comprising three eight bed residential units, an education unit, a recreational unit and an administrative unit. While located in and managed by the Northern Area Health Board, it provides a regional service for the Northern, South Western and East Coast Area Health Boards.

Between August 2002 and August 2003 five young people were admitted to Crannog Nua. Shortly before the inspection fieldwork commenced one of these young people was placed in a special care unit and another young person was placed in a detention centre. The remaining three young people were been cared for separately in each of the three accommodation blocks. Following inspection one of these young people was placed in a special care unit.

Crannog Nua had an operational strategy for opening each of the three units. This strategy was dependant on recruiting, retaining and inducting the required number of staff. The intention was to ‘roll out’ the service, so that rather than provide for full occupancy in unit 1 before the next unit opened, each unit would gradually open, providing for different rates of occupancy at different times. However this target was not met due to insufficient staff.

Considerable efforts had been made to recruit staff for Crannog Nua and management are commended for their work in progressing the recruitment process. Between May 2001 and June 2003 thirteen recruitment competitions were held for residential care staff, including three overseas competitions.

A policies and procedures document was devised to a high standard. Particular attention had been paid to the provision of staff support structures including a comprehensive induction programme. However the basic supports, staff supervision and attendance at staff meetings, had not taken place as intended. Supervision did not take place at the frequency required to support staff in their work, and staff meetings did not facilitate full staff attendance.

All of the young people had allocated social workers and care plans were provided for each of the young people. The requirement to hold statutory review meetings as outlined in the Child Care (Placement of Children in Residential Care) Regulations 1995 had not been consistently applied by the health boards. In general social workers and a guardian ad litem spoke of good working relationships with the management and staff of Crannog Nua. Social workers were aware of the difficulties the unit was experiencing at the time of inspection.

However they found that the young people had made progress in relation to education, personal development and family attachment issues.

Two parents interviewed by inspectors were very satisfied with the care their sons were receiving in the unit. They were satisfied that they were consulted in relation to their sons' care and were always informed of any significant events. They always felt welcome to visit. This finding was not reflected in the experiences of two people who wished to visit one of the young people.

On-site specialist clinical support is provided by the Mater Support Team on a half-time basis. The team consists of a senior clinical psychologist; a senior speech and language therapist and a senior systemic psychotherapist. Having a specialist therapeutic team on-site was a very valuable resource for Crannog Nua. However further clarity is required in relation to identifying team expectations and defining roles and responsibilities in order to maximise the level of integration between all aspects of the service.

Due to the fact that the three young people resident in Crannog Nua at the time of inspection were separated into the three accommodation units, inspectors were unable to observe group care and more usual every day activities. Records and interviews with staff and social workers stated that the young people had made progress in Crannog Nua. Despite some turbulent settling in periods, the young people had built relationships with staff and to varying extents, engaged with the educational and therapeutic programmes.

However by the time of inspection, Crannog Nua was not operating effectively and was experiencing considerable instability. Unauthorised absences had increased and some young people had been involved in damage to the unit, resulting in charges for criminal damage. Inspectors noted a high reliance on Garda intervention. Some of the staff were frightened of working with the young people. Some felt unsafe due to staff assaults in the past. Without doubt this has eroded their confidence which in turn eroded their capacity to diffuse and redirect potentially challenging situations.

Crannog Nua provides an on-site Special National School under the administration of the primary section of the Department of Education and Science. Individual educational plans are devised for each of the young people. Social workers and parents consistently commented on the progress the young people had made in school. Individual educational plans are devised for each of the young people.

In line with Article 17 of the Child Care (Placement of young people in Residential Care) Regulations 1995, an external monitor was contracted by the NAHB to monitor the service provided by Crannog Nua.

Given the above concerns and the extent to which Crannog Nua was operating in crisis at the time of inspection, SSI will return re-inspect the service in one year. The focus of the inspection will be to ascertain the extent to which the recommendations in this inspection report have been implemented.

## **2. Introduction**

The inspection of Crannog Nua High Support Unit (HSU) was carried out by the Social Services Inspectorate under the provisions of section 69(2) of the Child Care Act, 1991. It took place over a period of three days (9<sup>th</sup>, 10<sup>th</sup> and 11<sup>th</sup> September, 2003) and was preceded by a pre-inspection meeting with some of the staff and children. The inspectors involved were Ann Ryan (lead inspector) and Andrew Fagan (support inspector). Lorraine Edwards, inspector, also attended.

### ***2.1 Methodology***

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

- The young people's care files;
- All administrative records;
- Policies and Procedures;
- Census forms on the young people;
- Census forms on staff;
- Questionnaires completed by social workers and parents
- Health and Safety Statement;
- Health and Safety audit;
- Draft booklets for parents and young people;
- Staff induction programme and other documentation.

Interviews took place with management and care staff; supervising social workers; two of the young people; a guardian ad litem; the Assistant Chief Executive of the NAHB; members of the Mater Support Team; a member of the admissions and discharge committee, and the school principal. The lead inspector had discussions over the phone with two parents, the general practitioner, two people who had previously worked with one of the young people, and the external monitor.

### ***2.2 Acknowledgements***

The inspectors would like to express their appreciation for the co-operation received from all concerned.

### **3. Setting the scene:**

#### ***3.1 Background***

Crannog Nua High Support Unit was established in August 2002 in north Co. Dublin. It is based in a large purpose built facility comprising three eight bed residential units, an education unit, a recreational unit and an administrative unit.

While located in and managed by the Northern Area Health Board, it provides a regional service for the Northern, South Western and East Coast Area Health Boards. At the time of inspection Crannog Nua had been operating for one year. During that time five young people had been admitted.

High Support care provides a diverse range of provision with respect to the purpose and functions of units, the therapeutic models employed, the age ranges served and the duration of stay. High support can be designed around children living at home, in mainstream residential care, in designated high support units that provide for a small number of young people, or, as in the case of Crannog Nua, in a large purpose built facility for up to 24 young people. High Support care shares a number of characteristics. It provides additional support to young people with complex and often long standing needs. It is provided in a non-secure environment where the therapeutic relationship with staff is the main means of providing a secure setting for the young people's care. High staff ratios are a key characteristic of high support care. Access to therapeutic services is a further hallmark of high support care both in responding to the mental health and allied needs of the young people and in assisting staff to develop practices to deal with behaviours resulting from various and complex needs.

At the time of inspection Crannog Nua had been operating for one year and was still in a process of development and formation. Part of this development included learning from and mediating the tensions inherent in caring for young people presenting with significant need in an open setting, and in developing strategies in conjunction with the NAHB to resolve these issues.

On site clinical support was provided by the Mater Support Team. Members of this team commenced their work between January and March 2003. While providing a valuable resource to Crannog Nua, the development of an interdisciplinary team, including care staff and teaching staff was still in formation. Considerable efforts had been made to recruit staff. Despite this, difficulties were experienced in recruiting a sufficient number of trained and experienced staff, which in turn impacted on the centre's ability to implement the operational strategy for occupancy of all three units.

Inspectors were aware of the amount of preparatory work carried out by the director and her team in devising a policy and procedures document of high quality which reflected a commitment to 'getting it right' and trying to incorporate

lessons learned from other units. Inspectors are also cognisant of the challenges facing all new services of this nature and the initial problems that can be encountered in trying to match aspirations and reality.

At the time of inspection Crannog Nua was not operating effectively and was experiencing considerable instability. The capacity to manage young people who present with high risk and challenging behaviour was presenting serious difficulties for the unit. Some of the measures used to try to bring stability to the unit can be described as uncharacteristic and not representative of the quality of care provided by Crannog Nua over the previous year. Review of records showed that unauthorised absences had not been problematic over the previous year and staff negotiated different strategies with the young people to assist them in managing their behaviour more appropriately. Interviews with care staff, social workers and parents acknowledged that the young people had made progress in relation to education, personal development and family attachment issues.

However the fact remains that the situation found at the time of inspection, particularly in relation to management of challenging behaviour and unplanned discharges of young people, raised serious concerns about Crannog Nua's capacity to provide a service for troubled and troublesome some young people.

Given these concerns and the extent to which Crannog Nua was operating in crisis at the time of inspection, SSI will return re-inspect the service in one year. The focus of the inspection will be to ascertain the extent to which the recommendations in this inspection report have been implemented.

### ***3.2 Data on young people***

Since Crannog Nua opened in August 2002 five young people were admitted. Two had been resident for twelve months, one for nine months, one for eight months, and the fifth young person had been resident for three weeks prior to the inspection.

The young people, four boys and one girl, ranged in age from 13 years to 15 years. All of the young people had previous placements in residential care.

## **4. Standards: the findings**

### ***4.1 Statement of purpose and function***

**The unit has a clear written statement of purpose and function which accurately describes what the unit sets out to do with children and the manner in which that is provided. The statement is available, accessible and understood.**

Crannog Nua has a statement that defines the purpose and function of the unit, specifies the young people it caters for and the service it aims to provide. It states that the development of High Support Units was a response to '*the needs of a minority, but highly troubled, group of children and young people who require*

*intensive support away from home, cannot be supported in mainstream residential care facilities, and therefore require specialist residential care’.*

The admission criteria provides for boys and girls between the ages of 12-17 years who present with emotional and behavioural difficulties, where their behaviour poses a real risk to their health, safety, development and welfare unless placed in a HSU. Such behaviour and need is categorised as ‘moderate risk-high need’. Young people who present as ‘high risk-high need’ are not deemed appropriate for placement.

Inspectors are of the view that assessment is a process, not an event, and young people move between categories. Their behaviour can present as ‘high risk’ one week and low the next. It is difficult to envisage how Crannog Nua can avoid caring for young people who present with ‘high risk’ behaviour, at least some of the time. Inspectors were concerned about the appropriateness of the unit’s response to such situations.

Prior to the inspection fieldwork there were five young people resident in the unit. However over a short period before and after inspection, one young person was placed in a special care unit and another young person was placed in a detention centre. Therefore there were three young people resident during inspection. Following inspection one of these young people was placed in a special care unit.

Staff informed inspectors of their struggle to manage violent behaviour, some believing that the ‘wrong’ young people had been admitted. On the other hand inspectors were informed that, in the view of the NAHB board, all of the young people had been appropriately placed. Equally inspectors learned from social workers of the need for Crannog Nua to offer a service to needy, troubled, and acting out young people.

These differences must be addressed if Crannog Nua is to offer a service that responds to identified need and meets with the expectations of the NAHB. In the absence of this, as has been seen to date, the capacity of Crannog Nua to care for ‘*highly troubled young people*’ who present with challenging behaviour, is highly questionable.

#### **Recommendation:**

The board should ensure that the purpose and function of Crannog Nua is reviewed to more accurately reflect the identified needs of young people requiring high support and the unit’s capacity to provide a service for them.

#### ***4.2 Management and care staffing***

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

#### *4.2.1 Management*

A director and two deputy directors manage Crannog Nua. Each of the three residential units has a manager and deputy manager. The director reports to the Assistant Chief Executive of the Northern Area Health Board.

A management advisory group, chaired by the ACEO of the NAHB was established prior to the opening of the service. It met on one occasion mid 2002 during the initial set up stage. Representatives include members of the three boards in Eastern Regional Health Authority, the director and school principal of Crannog Nua, a representative from Child Psychiatry and three external representatives.

Inspectors heard that there has been some uncertainty as to the role of the committee, although it is primarily regarded as providing support to the director and the ACEO in managing the service. The policy and procedures document states that this advisory committee is responsible for advising on issues such as planning; monitoring; financial management; human resource management; service issues; operational issues; health, safety and welfare; and communication between the three boards.

Inspectors were told that a meeting will take place before the year end. Given the challenges facing any new service and the difficulties the service is presently facing, it is unfortunate that the director has not been able to avail of the advice and expertise of this committee. It is important that a meeting is convened sooner rather than later.

#### **Recommendation:**

The board should ensure that a meeting of the Management Advisory Committee takes place as soon as possible.

#### *4.2.2 Care staffing*

Crannog Nua had an operational strategy for opening each of the three units. This strategy was dependant on recruiting, retaining and inducting the required number of staff. Full occupancy of all three units required 69 staff and twelve relief staff. The intention was to 'roll out' the service, so that rather than provide for full occupancy in unit 1 before the next unit opened, each unit would gradually open, providing for different rates of occupancy at different times.

The staffing figures presented to inspectors show the staffing requirements required if the service was provided on a 'roll-out' basis, whereby the occupancy rate of each unit would gradually increase from 25% to 50% to 75% to 100%. Therefore when unit 1 had an occupancy rate of 75%, requiring 28.5 staff, unit 2 would then accommodate 25% occupancy, requiring a total of 43 staff, including 5.5 relief staff. Seventy-five percent occupancy of both units would require a total of 49 staff, including 6 relief staff. At that point, opening unit three at an occupancy of 25% would require 67.5 staff, including relief staff and so on. As stated, 100% occupancy rate, of all three

units, including the provision of live night staff, was 69 whole time staff and 12 relief staff.

Operational targets envisaged that the second unit would open in early 2003. However this target was not met due to insufficient staff. New staff that had been recruited for the second unit were deployed in unit I to make up for staff shortfalls. Staff induction for this unit was underway at the time of inspection.

Considerable efforts have been made to recruit staff for Crannog Nua. Up to the date of the staff census, documentation provided to inspectors showed that between May 2001 and June 2003 thirteen recruitment competitions were held for residential care staff, including three overseas competitions. By September 3rd 2003, these competitions resulted in 292 people being interviewed, of whom 123 people were panelled for positions, and out of whom 53 people took up positions. In the same time frame 20 care staff resigned.

Initially the recruitment process, which involved the NAHB, Crannog Nua and ERHA took approximately six months from initial advertisement to take up of positions. Delays were mainly at the point of taking up of references, garda clearances and negotiation of salary start up points. However following discussions with the NAHB the process was refined and it was reduced to a three month process. Managers in Crannog Nua are commended for work they carried out in the on-going recruitment of staff thereby shortening the recruitment process.

Apart from the national difficulties in recruiting trained and experienced care staff, inspectors were informed of other difficulties that have adversely affected recruitment, one of which related to differentials in pay scales. When pay scales were initially identified for Crannog Nua, the Department of Education special school scales were applied. The Department of Health and Children scales were later changed, which improved salary scales for residential care workers. Inspectors were informed that the NAHB is currently considering introducing these salary scales for Crannog Nua. Other IR issues related to conflicting views from those interviewed as to whether the board had approved the position of shift co-ordinators, and a delay in the recruitment of ancillary staff in preparation for the second unit opening. The merits or demerits of these issues are a matter for the health board. However a clear position needs to be adopted and communicated to staff and management.

There are two dimensions to meeting operational targets. One concerns recruitment issues as outlined above and the other concerns the operational strategy itself in terms of 'rolling out' the service.

The rationale for 'rolling out' was based on a number of issues. These related to the risk of staff becoming overwhelmed by caring for eight young people in the one unit in the early stages of development, with a concern that this could lead to high anxiety levels, reduced quality of care, and potential staff recruitment problems. Other considerations related to deploying some of the staff to a second unit thereby bringing greater expertise already developed in unit 1; and enjoying some economies of scale whereby, for instance, night cover in unit 1 reduces when unit 2

is operational because there is access to back-up staff in the event of problems developing.

While there are merits to the 'roll out strategy', these must be balanced with the potential for staff to become used to working with smaller numbers, so that when admissions increase, this in itself becomes a source of pressure and anxiety for staff, eroding their capacity to cope. Similarly inspectors question, as outlined in the operational strategy, the appropriateness of placing 2 young people (25%) in a unit built to accommodate eight residents for a number of months. In these circumstances their experience of care is one of relative isolation. It can also be argued that if the message they receive is that they need this level of supervision, they will act as though they do. It can also create a situation whereby if one young person is presenting with challenging behaviour, a position can be taken that the unit cannot accommodate another referral until that young person's behaviour improves, leaving a unit with a 25% or 50% occupancy rate for longer than was planned.

Inspectors are conscious of the fact that in planning for the service great attention was paid to getting it right and in learning from the experiences of other units. However at the time of inspection staff were experiencing anxiety and stress. The three young people were separated into three different units. Staff were working over time and managers had started to provide cover on shifts. There had been a number of staff assaults. These factors raised serious concerns about Crannog Nua's current capacity to provide a service for troubled and troublesome young people. The operational strategy for the service requires review. The experiences of Crannog Nua to date and the need to balance the expectations of external stakeholders requires that the operational strategy for moving forward is urgently reviewed.

**RESIDENTIAL CARE STAFF EXPERIENCE,  
STATUS AND QUALIFICATIONS**

CARE STAFF	LENGTH OF SERVICE IN UNIT	EMPLOYMENT STATUS	QUALIFICATIONS
Staff member # 1	8 months	Temporary	MA Religious Education BA Sociology
Staff member # 2	1yr 8m	Permanent	Cert. Hotel and Bar Mgt.
Staff member # 3	8m	Permanent	Child and Youth Worker Diploma
Staff member # 4	1yr 8m	Permanent	No qualification
Staff member # 5	3m	Temporary	BA in Human Services Assoc. Degree Human Services
Staff member # 6	3m	Permanent	Diploma Social Care
Staff member # 7	3m	Permanent	BTEC Dip. Social Care BA Social Care
Staff member # 8	1yr 9m	Permanent	Dip. Mental Health Nursing BA English and Philosophy
Staff member # 9	1yr 9m	Permanent	Dip. Counselling and Psychotherapy Dip. Human Growth and Development Degree in Theology Dip. in Supervisory Management.
Staff member # 10	7m	Relief	Dip. Social Studies
Staff member # 11	7m	Temporary	BA Applied Social Studies HNC social Studies GSVQ Arts and Social Sciences
Staff member # 12	1yr 10m	Permanent	Dip. Social Care Dip. First Line Mgt.
Staff member # 13	7m	Temporary	BA Psychoanalysis
Staff member # 14	7m	Permanent	BA Behavioural Science-Psychology Dip. Applied Social Studies
Staff member # 15	10m	Permanent	Cert. in Psychology inc. Brief Solution Therapy
Staff member # 16	1yr 9m	Permanent	Dip. Social Care Dip. Montessori Teaching
Staff member # 17	7m	Temporary	BA of Science in Psychology
Staff member # 18	3m	Permanent	NCVA Child Care 1-3
Staff member # 19	2yr 1m	Permanent	Post Grad in Education (Special Ed.) Dip. Mgt. And Business Studies BSc Zoology
Staff member # 20	1m	Temporary	BA Social Studies with Women's Studies

Staff member # 21	10m	Permanent	BA Social Science
Staff member # 22	1yr 6m	Permanent	Dip. in Child Care
Staff member # 23	7m	Permanent	BTEC Diploma NVCA Cert. of Achievement
Staff member # 24	7m	Temporary	Dip. in Youth and Community Work
Staff member # 25	1yr 9m	Permanent	Nat. Cert. Business Mgt. HNC Community and Economic Development
Staff member # 26	1yr 10m	Permanent	MA Youth and Community Studies Dip. First Line Mgt.
Staff member # 27	3m	Temporary	BSc Psychology MSc Health Psychology Post Grad Cert. in Further and Higher Education
Staff member # 28	1yr 6m	Permanent	Diploma in Counselling Diploma in Addictions Studies Diploma in Psychology and Criminal Behaviour
Staff member # 29	1m	Permanent	Psychiatric Nursing
Staff member # 30	1yr 2m	Permanent	Diploma in Social Studies
Staff member # 31	11m	Permanent	Diploma in Social Science
Staff member # 32	1yr 5m	Permanent	Diploma in Applies Social Studies Post Grad Dip in Child Protection Post Grad Economics and Care Mgt
Staff member # 33	7m	Temporary	No qualification
Staff member # 34	7m	Temporary	Diploma in Law and Security
Staff member # 35	1yr 9m	Permanent	MA Psychology Post Grad Cert Abnormal Psychology
Staff member # 36	2yr 7m	Permanent	Diploma Applied Soc. Science BSc and MS.Sc (Criminology)
Staff member # 37	7m	Temporary	Diploma in Social Care Diploma in Social Work
Staff member # 38	7m	Temporary	DEC in Special Care Counselling
Staff member # 39	1yr 7m	Permanent	Nat. Dip. Social Care

In addition to the above qualifications some members of staff had reached certificate level in counselling, solution focussed brief therapy, staff supervision, reality therapy and holistic healing. Two members of staff were TCI trainers.

Inspectors reviewed documentation on staff vetting in relation to fifty staff, including ancillary staff. Garda clearance and references were available for all staff.

While two references were available for all care staff, the board's attention is drawn to the Department of Health and Children's guidelines on staff vetting, dated November 1994, which requires that three references are sought for employees.

#### *4 2.3 . Supervision and support*

Formal supervision of care staff is provided by unit managers and deputy managers. The deputy directors provide supervision for the unit and deputy unit managers. The policies and procedures states that staff supervision should take place every three weeks. This level of frequency has not been achieved. Of those staff who were employed for the year prior to inspection formal supervision was provided on average

4 times. For those who started in December 2002, supervision was generally provided 3 times over the previous nine months. Supervision for unit managers and deputy managers was generally provided on a monthly basis.

Inspectors were informed that the timetable makes it difficult to schedule supervision. The ideal time to hold supervision is the morning times, but not all staff are scheduled to work mornings, and in addition, if a crisis arises in the unit, the opportunity is lost and may not come around again for a number of weeks. While efforts have been made to ring-fence certain times for supervision, staffing levels had not permitted this.

Other sources of staff support provided were weekly staff meetings, fortnightly clinical consultation meetings, with the Mater Support Team, group practice meetings, and staff facilitation meetings with a staff consultant. However staff meetings were not currently rostered for, so that the full team did not attend staff meetings, and some of those on duty had to provide cover in the unit while the meetings were taking place. Similarly, while staff described the clinical consultation meetings as beneficial to them, they were not always free to attend these meetings. Group practice meetings between unit managers and staff to address specific care issues took place during the winter months. The staff consultant worked with small groups of staff. This resource had initially been introduced as a means of facilitating two different staff teams in working together. However it was difficult to gain a common understanding as to the current purpose of this facility, and management acknowledged that it was under review.

The unit is commended for the efforts they have made to put support systems in place for staff. However the basic supports, staff supervision and attendance at staff meetings, have not taken place as intended. Supervision does not take place at the frequency required to support staff in their work, and staff meetings have not facilitated full staff attendance. In addition, the fact that some staff have not been able to avail of the supports provided has left them with a sense of being under valued. Inspectors recommend that management review the supports that are available, put the basics in place in the first instance, and then build from there. Staff would benefit from a more limited but dependable support structure i.e. one weekly staff meeting, that is rostered for, and attended by all members of the inter-disciplinary team.

#### *4.2.4 Training and development*

Management are commended for the attention paid to staff induction. An induction programme developed in partnership between Crannog Nua and The Dublin Institute of Technology was provided for all of the residential care staff. This included policies and procedures of Crannog Nua; introduction to supervision; principals of group work; child protection (rights and complaints); standards in residential care and the role of SSI; the role of the education team and the Mater Support Team; supporting best practice; Children First; first aid; child development – effects of traumatic experiences and attachment difficulties; placement planning; report writing and record keeping; team dynamics; fire safety; pin-point and manual handling. All have received training in Therapeutic Crisis Intervention (TCI).

Following a review of the length and content of the induction programme, it was reduced from ten weeks to 6/7 weeks. Other changes included providing those parts of

the course delivered by DIT off-site, to limit the distractions that had been experienced on the unit and to provide a more suitable environment. One of the deputy directors was also appointed as a course co-ordinator to liaise with the participants, DIT and Crannog Nua Management to ensure the smooth running of the course.

In addition to the above, external training was provided for members of the management team in relation to Project Management; Interviewing Skills; Trauma, Attachment and Relationships; and Management Skills and Team Building.

### **Recommendations:**

The board should ensure that any outstanding IR issues are addressed and the board's position communicated to staff.

The board should ensure that the operational strategy for Crannog Nua is reviewed.

The director should ensure that a programme of regular supervision takes place and that all staff are facilitated to attend a weekly staff meeting.

#### *4.2.5 Administrative files*

A number of administration/operational records are maintained in the residential units including a fire register, complaints book, sanctions book, health and safety check lists, and other operational check lists. As stated in section 4.5.8, a master file and a placement plan is maintained for each young person. These files contain records in relation to the use of physical restraint, unauthorised absences, and significant events. Section 4.5.8 refers to the need to simplify the filing system to avoid duplication and provide greater ease of access to information.

#### *4.2.6 Notification of significant events*

Social workers are informed of all significant events, including the use of physical restraint, unauthorised absences, and other events affecting the young people.

#### *4.2.7 Register*

A register is kept of all young people admitted to the centre. The information kept on the register is returned to the NAHB. It states the name of the young person, the date of admission, the relevant community care area, and the date of discharge and the destination to which the young person was discharged. The Child Care (Placement of Children in Residential Care) Regulations, 1995 requires that the sex, date of birth, and the names and addresses of the parents of the young people are also recorded on the register.

### **Recommendation:**

The director should ensure that the register is amended to include all details required by regulation.

### 4.3 *Monitoring*

**The Health Board, for the purpose 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.**

In line with Article 17 of the Child Care (Placement of young people in Residential Care) Regulations 1995, a monitor is contracted by the NAHB to monitor the service provided by Crannog Nua.

Based in Scotland, the monitor carries out monitoring visits approximately every six weeks. While the first visit took place over three days the monitoring visits since then are one day visits. Six visits have taken place to date.

During his visits the monitor has met with staff, both individually and in groups. He has attended management meetings, and has met with the Mater Support Team and the induction course providers from DIT. He has spent time with the young people through informal activity and meal times. He has not yet met with social workers or parents of the young people, but it is his intention to do so. He monitors documentation in relation to significant events including the use of physical restraint. In line with the regulations the monitor will submit a monitoring report to the NAHB on an annual basis, the first of which will be due at the end of 2003.

During the earlier part of the year the monitor was engaged in familiarising himself with the service provided, the policy and procedures that inform practice, and the staff team that provides the service. Inspectors commend the appointment of a monitor for Crannog Nua. The monitor is viewed by management as a supportive resource for their work. However it is now timely to review the development of this role. Inspectors recommend that a schedule of monitoring visits is devised that outline a systematic approach to ensuring that the requirements of each of the relevant standards are complied with. While an annual report will be produced by the monitor, inspectors also recommend that a format for reporting on an interim basis to the ACEO and the management and advisory committee is agreed.

#### **Recommendation:**

The board should ensure that a schedule of monitoring visits is devised to ensure that the requirements of each of the relevant standards are complied with. A format for reporting on an interim basis to the ACEO and the management and advisory committee should be agreed.

### 4.4 *Children’s rights*

**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.**

#### *4.4.1 Access to information*

Young people have access to their daily progress reports. They also have access to review reports prior to their review meetings which affords them an opportunity to comment on the content and to assist them in expressing their views at the review meetings. However staff were uncertain as to whether the young people could have access to their master file, which is maintained in the administration unit. Inspectors were informed that if a young person requested access to this file the care staff would refer this to management.

The unit has a policy on young people's right of access to information recorded about them. It should be amended to include the right of young people to access their master files and how this right should inform practice in the young person's best interest.

#### *4.4.2 Consultation*

There was evidence of consultation with young people through discussion with their key-workers and by attendance at their review meetings. Young people's meetings were another forum for consultation with the young people, particularly in relation to daily issues and routines.

Inspectors were concerned to learn of the circumstances in which a young person was informed of the decision in relation to his discharge to a special care unit. This is discussed under the relevant section 4.5.7.

#### *4.4.3 Complaints*

The unit had a written policy for responding to complaints made by the young people. Parents and social workers were informed of any complaints made by the young people. The procedure was well documented and as a safe guarding measure practice was reasonably good.

Practice in responding to complaints does not reflect the written procedure as outlined in the policy and procedures document. There is no evidence, as stated in the policy document, that there is a designated support person for the complainant, and a meeting is not always convened with the young person, family member, key worker, social worker, unit manager and deputy director, to discuss the nature of the young person's complaint. It is not always recorded that the young person was informed of the outcome of their complaint or that they were offered the option of taking the matter further if unhappy with the outcome of their complaint.

Though there is evidence of complaints being channelled into the Child Protection System, inspectors recommend that the two systems are separated in the policy and procedures document, while at the same time maintaining clarity that a complaint can lead to a child protection assessment in certain circumstances.

#### **Recommendations:**

The director should ensure that the unit's policy and procedures document is revised to:

- include the right of young people to access all information recorded about them and how this right should inform practice in the young person's best interest.
- provide a separate section on a young people's complaints procedure that reflects actual practice.

#### **4.5 Planning for children and young people**

**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.**

##### *4.5.1 Suitable placement and admissions*

Admission criteria for prospective referrals to Crannog Nua is detailed in the policy and procedures document. This document also includes guidance on the pre-admission process and a draft information booklet is available to the young people and their parents. Commendably the pre-admission process facilitates visits from the young people to familiarise themselves with the unit, other residents, staff and routines.

Supervising social workers were satisfied that referral and admission to Crannog Nua had been suitable for all of the young people. However the question of suitable admissions is linked to that of purpose and function. Caring for some of these young people, all of whom were considered suitable admissions, has presented serious difficulties for the service. In terms of outcomes, what was considered a suitable admission only remains so if the young people can move on in a planned manner, and where placement in Crannog Nua does not result in yet another experience of placement breakdown. The issue of suitable referrals has been discussed under the standard on purpose and function, 4.1.

All referrals are considered by an admissions and discharge committee. At the time of inspection the committee had met on three occasions, August 2002, October 2002 and April 2003. Over the course of these meetings 30 young people were considered. As of from April 2003, the decisions taken in relation to these referrals were as follows: five young people were offered placements, which were accepted; an additional three had been offered placements, which were not taken up; ten more were considered suitable, but the staffing levels could not accommodate admitting these young people. The remaining twelve young people were either considered unsuitable for placement (6); the referral was not considered due to insufficient information provided by the young person's social worker (3); a referral was made for psychiatric assessment (1) or circumstances had changed since referral (2).

Of the six referrals that were considered unsuitable, 1 was too young; 4 were considered unsuitable due to risk of absconding; 1 due to risk of absconding and drug misuse.

A sub-committee of the admissions and discharge committee reviews applications in advance of the full committee meeting, and presents the committee with a list which identifies those referrals deemed most appropriate and those that are less appropriate. While this system limits the range of people reviewing the preliminary list, it was introduced because of the considerable amount of reading that is necessary in relation to each referral.

Inspectors were informed that the policies and procedures of the admissions and discharge committee were under ongoing review. Inspectors recommend that the committee considers the following as part of their review:

- The admissions and discharge committee should meet on a more regular basis.
- Where sufficient information has not been provided by social workers, consideration of referrals in some instances have been postponed until the following referral meeting. At the frequency of meetings, this could result in a delay of 6 months before a referral is considered. The committee should review how this situation could be avoided.
- Social workers are unable to receive any information as to a likely date for admission, even where a referral is considered suitable for placement. While inspectors are aware that waiting lists may create expectations that cannot be met, the committee should develop some criteria that will inform the date of placement.
- The admissions and discharge committee should distinguish between the information that is required to inform the suitability of placement and that information that could be provided at a later stage if and when a placement is offered.
- The need for a psychiatric assessment to inform the referral should be reviewed particularly in situations where a young person has not previously been involved with the psychiatric service.

Finally, all efforts should be made to ensure that the referral procedure is as helpful as possible. Where procedures are burdensome referring social workers lose faith in the system and the service's commitment to working with the young people.

### **Recommendation:**

The board should ensure that the referral procedure is reviewed.

#### *4.5.2 Statutory care plans and care plan reviews*

As part of the referral and admissions criteria care plans are provided for each of the young people. It is not however consistent practice to update care plans following review meetings. Statutory care plans should be updated following each statutory review meeting, outlining the decisions made in relation to the

effectiveness of the placement within the context of the care plan, stating objectives to be achieved, including objectives in relation to moving on within a particular time frame.

The requirement to hold statutory review meetings as outlined in the Child Care (Placement of Children in Residential Care) Regulations 1995 has not been consistently met by health boards. According to regulation statutory review meetings should take place two months after placement and at six monthly intervals thereafter during the first two years of placement. Four of the young people were resident in the centre for more than two months. Their first review meetings had taken place four, six and seven months respectively after placement. The first review meeting for the fourth young person was planned to take place a year after placement.

Inspectors noted some confusion amongst social work staff about the purpose of placement review meetings and statutory review meetings. Regular placement review meetings are convened by the unit at intervals of six weeks. The purpose of these meetings is to focus on the young person's placement in relation to individual objectives set and progress made. Practice in relation to involvement at these meetings of young people, parents, and relevant professionals was good. However placement plans could better reflect how young people have progressed through the different phases of placement and the goals that have been achieved including the therapeutic placement goals as identified by the Mater Support Team.

Placement review meetings give precedent to placement issues rather than the overall care plan. Clearly the findings of placement review meetings will inform the statutory care plan reviews particularly in terms of progress made, objectives achieved and moving on and after care plans. However they are not statutory review meetings. The social work department has responsibility for the care planning process. Statutory review meetings, convened and conducted by social work managers, should take place at intervals required by regulation.

### **Recommendation:**

Principal Social Workers should ensure that statutory review meetings take place at intervals required by regulation. Care plans should be updated following review.

#### *4.5.3 Contact with families*

The unit's policy and procedures document makes one reference to parents and one reference to visits to residents and contact with families. The reference to parents/guardians outlines five rights in bullet-point form, stating that parents have the right to involvement in decisions concerning the young people's care, to receive information concerning young people's progress, to complain if they have concerns, to be involved in working with care staff and social workers in planning and caring for the young person, and to be informed of any significant event which may affect the young person's well being. This section in the policy and

procedures manual could usefully be revised and extended to outline ways in which parents and significant others will be engaged in the decision-making and care of their children. The reference to visits to residents states that the unit recognises the important need for contact with family members and significant others and that it supports and encourages such contact.

Inspectors talked to two parents and two other people who had previously worked with one of the young people and wished to maintain contact with him. The two parents were very satisfied with the care their sons were receiving in the unit. They were satisfied that they were consulted in relation to their sons' care and were always informed of any significant events. They always felt welcome to visit.

The reference to visits to residents states that the unit recognises the important need for contact with family members and significant others and that it supports and encourages such contact. This policy was not reflected in the experiences of the two people who wished to visit one of the young people. Both of these adults had cared for the young person in a previous residential care setting. Inspectors learned of the attempts made by these two people at different times to visit and/or provide outings for this young person. Whilst providing the necessary information to meet vetting requirements, they experienced, over a number of months, numerous barriers to accessing and maintaining a relationship with the young person. Inspectors learned of inconsistencies in approach amongst different staff members; planned visits being cancelled at short notice; a distinct lack of co-ordination in relation to progressing visits to the young person; and lack of clarity in relation to the policy on visits.

Following a complaint made by one of these people he received a visit from two senior members of management in which the unit accepted responsibility for what had taken place. Inspectors were informed that the situation was a result of poor communication amongst staff and a lack of clarity in relation to the unit's procedures. Practice had also been based on a concern to ensure the young person's safety. Inspectors acknowledge the importance of ensuring that safeguarding practices are in place. However, after appropriate steps have been taken in relation to vetting procedures, there should be no delay in making a decision, in consultation with the young person's social worker in relation to visitors. All efforts should be made to pro-actively support and facilitate contact with significant others in the young people's lives.

Practice in relation to the above was of considerable concern to inspectors. The circumstances of the young person were such that the possibility of contact with past carers, through both visits to the unit and trips outside of the unit, as had been offered, were particularly relevant. The importance of young people in care having contact with people outside the centre is well known and should be encouraged.

Inspectors were informed that practice in relation to young people's access to significant others in the community has been reviewed and rectified.

**Recommendation:**

The director should ensure that practice in relation to young people's access to significant others in the community is continually monitored.

#### 4.5.4 *Social work role*

**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.**

All of the young people had allocated social workers. As part of the admission and referral process social workers provide written care plans and other background information on the young people. As stated in section 4.5.2 greater attention should be provided to convening statutory review meetings within the frequency required by regulation.

In general social workers visited on a monthly basis, although one social worker did not visit for a three month period. While this meets the minimum statutory requirements in relation to supervision and visiting, inspectors consider that it is not of sufficient frequency for a young person in a high support environment. On social worker visited fortnightly. They see the young people in private. It was not practice for social workers to read the young peoples' daily log books or other records. Only one social worker had read records maintained in the unit on one occasion.

All of the social worker's viewed admission to Crannog Nua as an appropriate placement of the young people. In general social workers and the guardian ad litem spoke of good working relationships with the management and staff of the unit. Social workers were aware of the difficulties the unit was experiencing in managing young peoples' behaviour and had concerns, at the time of inspection, about the fact that the young people were separated into three units. However they also acknowledged that the young people had made some progress in relation to education, personal development and family attachment issues.

Discharges should take place as part of the care planning process. The circumstances prevailing in the unit in recent times did not accommodate this process. Instead, when a unit is in crisis decisions can be taken based on the perceived needs of the service, and severe pressure is brought to bear on social work staff and unit staff working in partnership in the best interests of the young person. This issue is further discussed under the standard on discharges.

#### 4.5.5 *Emotional and specialist support*

Following consultation between the NAHB and the Mater Child and Adolescent Mental Health Service during 2002, an agreement was reached for the provision of on-site specialist clinical support. The Mater Support Team (MST) consists of a senior clinical psychologist, who works two days per week, a senior speech and language therapist and a senior systemic psychotherapist, both of whom work 2.5 days per week. The team members took up their posts between January 2003 and end of March 2003. It is envisaged that a consultant psychiatry service will become available for

two sessions per week from a forensic post yet to be established. In the meantime, psychiatric assessments are provided through the Mater Child and Adolescent Mental Health Service on request.

The systemic psychotherapist is the current team co-ordinator. However it is envisaged that this role will rotate on a yearly basis. He attends management meetings and sits on the admissions committee. The work of the team was described as providing support and consultation to the management and care teams, and through specific clinical roles, working with the young people and family members.

Individual work with the young people includes psychological assessments and identification of therapeutic goals. Speech and language therapy is delivered in the school, integrated into the curriculum as a 'communications' class. The psychologist and speech therapist have jointly worked on intervention programmes in relation to social skills training and anger management. The systemic psychotherapist, recruited in March 2003, provides a service to parents to offer them support, to keep young people connected to their families, to work on unsolved issues between the young person and their families, and to help parents look at ways they can actively support the young person's care plan. The MST attend the young people's placement review meetings.

In relation to staff support, the MST provide fortnightly clinical consultation meetings for the care staff to offer support and consultation in relation to the care of the young people. Members of the team also attend part of the staff meetings. Liaison with key workers is provided in relation to goal setting and solution-focussed work around behavioural management issues. Weekly hand-over meetings take place between the MST and members of the care management team. Staff are also supported on an individual basis and the MST provide critical incident debriefing sessions on an individual and group basis.

Staff members describe the MST as being very supportive. However staff were unclear about whether or how their interventions with the young people were informed by the MST. To some extent this may reflect the fact that as an interdisciplinary team, both the MST and the care staff are still a team in formation. How the resource provided by the MST is maximised in relation to informing and guiding interventions with the young people requires further development.

Having a specialist therapeutic team on-site is an extremely valuable resource for Crannog Nua. At the time of inspection the MST had been in operation for approximately five months. Achieving an integrated model of care has been a goal from the outset and work continues towards maximising the level of integration between all aspects of the service. Identifying team expectations and subsequently defining roles and responsibilities is required to enhance this process so that there is a better integration of services within the organisation.

### **Recommendation:**

The role and responsibilities of the Mater Support Team should be reviewed towards the development of a more integrated model of care.

#### 4.5.6 *Preparation for leaving care and aftercare support*

The policy and procedures document states that the length of stay is determined by the need of the young person for a high support placement. Inspectors consider that both care plans and placement plans should state target outcomes as well as the needs and aims of placement. By stating target outcomes at review meetings the young person is given a clearer understanding and sense of ownership over his/her placement.

Section 4.5.7 provides details of unplanned transfers/discharge of three of the young people.

A planned discharge for the fourth young person to a mainstream residential unit was due to take place. The young person's placement plan outlined goals in relation to preparation for moving on, including unsupervised time outside of the unit.

#### 4.5.7 *Discharges*

Since the unit opened five young people were admitted. One of these had been transferred to a special care unit, shortly before inspection. Another was transferred to a special care unit shortly after inspection. The third young person was remanded in a special school. Inspectors were informed that two of these 'transfers' were on a temporary, though open-ended basis, until it was deemed appropriate for the young people to return. At a later date both were re-admitted to Crannog Nua. The third young person was discharged.

None of the three changes in placement could be considered to have taken place in a planned step down manner. All were as a result of the young people presenting with 'at risk' or challenging behaviour that the unit did not have the capacity to manage. This issue is discussed in section 4.6.4.

Inspectors noted the strongly held view that one young person's discharge was urgently needed, which conflicted with the view held by the social work department. The urgency with which the unit believed this should take place was of concern, and inspectors are of the opinion that this decision was a reflection of the crisis in which the service was operating. When the decision was taken that the only course available was to discharge the young person, this became the focus, and the service became closed to considering how best to re-engage the young person. There needs to be clarity at the point of admission about the circumstances in which a young person can be transferred to another unit and, this should not happen unless it is written into the young person's care plan.

Inspectors were concerned to learn of the circumstances in which this young person was discharged. A decision was taken that he was not to be informed of his discharge to a special care unit until the evening of the day the special care order was granted. The reason given to his social worker for not informing him that a special care order was being sought, was that his behaviour would escalate and present management problems for staff. On hearing of his discharge he was

very distressed and angry. This young person had been resident in the unit for one year. Certainly there was every likelihood of the young person becoming very distressed and angry on hearing of his discharge. However between care staff, management, the mater support team and his social worker, an agreed approach to informing him of his discharge and a contingency plan for managing his reaction should have been put in place a number of days prior to discharge.

Crannog Nua's explanation for this situation was that the unit had managed a critical situation which had been created by a 'system' failure. The 'system' failure resulted in a failure to respond in a timely manner to securing another placement for the young person, and delays in making an application to and getting a response from the special care unit as to whether the referral was accepted, all of which prevented Crannog Nua from informing the young person about, and preparing him for, his discharge. Clearly the social work department and Crannog Nua disagreed about what was in the young person's best interests. Inspectors are of the view that this resulted in a stand-off situation which was ultimately resolved by intervention at senior board level resulting in a placement being secured in special care. Inspectors were informed that responsibility for discharge is shared by the social work teams and Crannog Nua and involves on-going dialogue and decision making and that in crisis situations severe pressure is brought to bear on this process. While this was clearly the case in this instance, none of these details change the fact that the manner in which the young person was discharged represents poor child care practice.

The policy and procedures document states that the admissions and discharge committee will review all cases recommended for discharge. Inspectors consider that the policy document should include the committee's important gate-keeping role in relation to discharges, including those placements that end in an unplanned manner. This did not take place in relation to the three young people who had been transferred/discharged.

**Recommendation:**

The NAHB should review the circumstances relating to the transfer/discharge of three of the young people.

*4.5.8 Children's care records*

The young people's main records consist of a master file kept in the administration unit and a placement plan maintained by the young person's key-workers and kept in the accommodation units.

There is a large quantity of information maintained about the young people. The intention to introduce a filing system that was comprehensive is clear. However the method adopted for keeping records is burdensome and does not facilitate ease of access to information. While efforts had been made to standardise how information was maintained, the standard of filing was uneven.

Information in the young peoples' master files is filed in chronological order relating to incoming and outgoing correspondence. These files (each young person can have 3-4 files) contain information in respect of referrals; care planning and review; assessment; social history, education, medical and other relevant reports. However, despite the cover sheet for each file, because data is filed chronologically, it is difficult to trace information, particularly in relation to care planning and review. In some instances review reports were unsigned and undated. While care files contained reports for placement reviews inspectors were not always able to locate minutes of these meetings. The system also can imply mis-filing as for example inspectors read a letter of complaint from a social worker which was filed between two review reports, because of the date on which it was received.

The system of filing in relation to master files requires review to provide ease of access to information and to provide for accountability and monitoring purposes.

The placement plan maintained by the young person's key-workers is divided into twenty sections. These plans contain information in relation to all aspects of their care. They include records in relation to case history and assessment; individualised planning and goals; register of significant events; case reviews; TCI and LSI records; drug administration; individual crisis management plans and so on. Inspectors were struck by the amount of duplication contained in these plans, mainly due to a number of pro-forma that record information that is found on other recording forms. In addition, because information can be recorded on different pro-forma, different key-workers record in different places. Some of placement plans were completed to a higher standard than others. Some provided comprehensive information on the aims of placement and goal set. Some were incomplete in relation to goals set and assessments carried out. When questioned about why certain sections were not completed suggestions were made to inspectors as to where the information 'might' be contained.

Clearly this filing system places a burdensome administrative task on key-workers. A review of all pro-forma is required and duplication of information removed. The unit could also usefully consider separating that part of the placement plan that actually informs and guides the 'plan'. This would include the sections dealing with assessments, goal planning and on-going individualised objectives, including outcomes. If devised differently it could also be presented at review meetings as a concrete account of individualised placements objectives, target outcomes and progress made between reviews. Currently it presents more as an administrative record for whom key-workers hold responsibility rather than a working tool to inform and guide practice in a manner that reflects an integrated model of care.

#### **Recommendation:**

The director should ensure that a review of the children's care files takes place.

#### **4.6 Care of young people**

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

#### *4.6.1 Individual care in group living*

Records and interviews with staff and social workers stated that the young people had made progress in Crannog Nua. Despite some turbulent settling in periods, the young people had built relationships with staff and to varying extents, engaged with the educational and therapeutic programmes.

Due to the fact that the three young people resident in Crannog Nua at the time of inspection were isolated in separate units, inspectors were unable to observe group care and more usual every day activities. However, review of records showed evidence of planned individual work with the young people. All of the young people were assigned two key workers. Individual contracts were devised in consultation with the young people around such issues as the use of games, tv, and activities. Individual placement goals identified issues such as anger management, self-care, school attendance; improved behaviour in relation to certain daily routines; and improved communication and contact with families.

The young people's individuality and preferences were taken into account in organising outings and activities, including trips to the beach, an internet café, fishing, cinema and other sporting activities. A well organised summer programme had been implemented. Inspectors read of a surprise birthday party organised for one young person and a plan to support another young person around the time of bereavement.

The young people have a clothes allowance and they accompany staff to buy their clothes. The young people's privacy is respected in relation to making phone calls and receiving mail.

Records suggest that at different times in the young people's placement they experienced a measure of consistency and clarity of expectations. They also experienced the commitment and care of the staff team. However, the findings under a number of the standards show that Crannog Nua was not operating effectively in recent times, and as described to inspectors, was in crisis. The situation that obtained in Crannog Nua at the time of inspection did not support good care practice. An atmosphere of crisis militates against the staff's ability to create stability, continuity and to building attachments with the young people.

#### *4.6.2 Provision of food and cooking facilities*

A varied and nutritious was served to the young people and all efforts were made to accommodate individual tastes.

#### *4.6.3 Race, culture, religion, gender and disability*

The policy document states that the programme of care promotes respect for the young person, their culture, religion, sexual orientation, and family background.

At their own wishes, none of the young people attend religious services. One member of staff has been in contact with a local priest in relation to one young person's

confirmation. There has been discussion about seeking a chaplain for Crannog Nua but this has not taken place.

#### *4.6.4 Managing behaviour*

At the time of inspection the service was in crisis. The capacity to manage young people who present with high risk and challenging behaviour was presenting serious difficulties for the unit. Staff talked of the ‘wrong’ young people being admitted, of the fact that they felt unsafe, of the number of staff assaults that had taken place, and some described their role in terms of appeasing the young people.

From interviews with management, staff and others, this time was regarded as the unit’s lowest ebb. From the initial establishment of Crannog Nua, young people had presented, at certain times, with challenging behaviour. Following some of these incidents there was evidence that Life Space Interviews had been used very appropriately and key worker sessions had discussed and negotiated different options for assisting young people to manage their behaviour more appropriately. Some of the young people had attended anger management sessions with the Mater Support Team.

However by the time of inspection, the young people’s behaviour was not being managed. Unauthorised absences, which had not been problematic during the previous twelve months, had increased, and some young people had been involved in damage to the unit, resulting in charges for criminal damage. One young person was remanded to a special school, less than a month after placement. Another was transferred to a special care unit as a result of safety concerns during unauthorised absences. A third young person was discharged to special care shortly after inspection. At a later date two of these young people were re-admitted to Crannog Nua.

Inspectors noted a high reliance on Garda intervention. One log book entry stated that the Gardai were called because the young people were moving furniture around and refusing to take direction from staff. Another stated ‘x refused to go to bed tonight, police were called as young people were talking of weapons and violence’. Inspectors consider that using the Gardai in this way has created more problems than it solved. Young people are likely to have picked up the message that the staff cannot cope with them, thus making the problem of behaviour management even worse.

Inspectors were informed that the decision to separate one of the young people was based on his need to ‘stabilise for his through-care plan’. The decision to separate a second young person was taken at a multi-disciplinary team meeting, which included his social worker. A view was taken that he was unable to manage group living at the time and needed time to stabilise away from the group before moving back. The decision to separate the third young person was that he presented with risk levels beyond the legal mandate of high support care. Notwithstanding the rationale for these decisions, the separation of the remaining three young people into the three different units was of concern. It placed greater pressure on limited staff resources to staff three units. It facilitated a sense amongst all that the young people needed ‘to settle’ before staff could begin to work with them together again and resume normal routines. The facility to ‘special’ the three young people is not one that will be available when

numbers increase and should not be relied upon. Perhaps most importantly, it imparts a message to young people that this is the only way staff can manage their behaviour.

Some of the staff felt unsafe working with the young people due to staff assaults. This has eroded their confidence which in turn has eroded their capacity to diffuse and redirect potentially challenging situations. It also limits their capacity to place appropriate boundaries and expectations on the young people which accounts for some of the staff views that they were just appeasing the young people.

The main challenge for managers of this service is to assist staff in working with troubled young people who will invariably present with challenging behaviour. Staff and management must critically evaluate their response to challenging behaviour.

### **Recommendation:**

The board should ensure that Crannog Nua's response to challenging behaviour is critically evaluated.

#### *4.6.5 Restraint*

Crannog Nua has a policy on the use of physical restraint. The only acceptable form of physical restraint are holds associated with the therapeutic crisis intervention (TCI) method. All staff are trained in TCI as part of their induction programme.

There were standard forms for recording TCI restraints. The use of physical restraint is monitored by management and TCI forms are reviewed and monitored by the external monitor. Parents and social workers are informed of incidents involving physical restraint.

There were 48 incidents of physical restraint involving four young people over the previous year. Thirty-three of these related to one young person. The remaining restraints related to three young people and took place 6,7, and 2 times respectively. The use of TCI has not always involved physical restraint. Records show appropriate use of Life Space Interviews with the young people.

#### *4.6.6 Absence without authority*

There is a written policy and procedure for staff to follow when young people are absent without authority, including those to be notified. This procedure has been followed in relation to unauthorised absences.

Between September 2002 and end of July 2003 there were 22 unauthorised absences in respect of four young people. One young person was involved in 15 unauthorised absences and the others were involved in 4, 2 and 1 respectively. Of the 15 unauthorised absences of one of the young people, nine were for thirty minutes or less and five were for less than an hour. In the majority of incidents the young person returned to the campus herself. Clearly she was not running away from the unit but rather leaving the campus without permission.

During the period August 2003 and September 2003 there were 16 unauthorised absences involving five young people, one of whom had been admitted mid-August. The concerns raised as a result of one young person's absence over three days during this time resulted in her referral to and placement in a special care unit.

Caring for troubled young people is a continual balance of risks. Even if the risk involved takes place during an unauthorised absence, the staff must be confident that they have exhausted all possibility of re-engaging the young person, before discharge is considered. This is less likely if the unit is in crisis.

Following previous unauthorised absences young people were re-engaged by staff and continued with their programme of care. However by September 2003, in line with difficulties staff were experiencing in managing behaviour, there was a greater focus on seeking answers outside of Crannog Nua – solutions viewed in terms of young people's transfer or discharge.

#### ***4.7 Safeguarding and child protection***

##### *4.7.1 Safeguarding*

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

The policy and procedures manual provides guidance for staff in relation to safe guarding practices. The responsibility of staff to report any suspicion that a staff member, or other person, is acting inappropriately is clearly outlined. It also contains guidance in relation to professional boundaries and one-to-one contact with the young people.

Inspectors found no evidence to suggest that the young people in Crannog Nua were at risk of harm except in so far as the management of difficult behaviour placed both staff and young people at risk of injury. The young people have access to the unit's child protection liaison co-ordinator (deputy director) and the external monitor. They can make phone calls in private. As a safe guarding measure practice in relation to the young people's complaints procedure is reasonably good, and parents and social workers are informed of significant events.

One safe guarding measure was not operating as effectively as it could. This relates to the difficulties experienced by two people in relation to visiting a young person (4.5.3). Recommendations in relation to this safe guard has been made under the relevant standard.

##### *4.7.2 Child protection*

**There are systems in place in the unit to protect young people from abuse. Care staff are aware of and implement practices which are designed to protect young people in care.**

Crannog Nua has written policies and procedures consistent with the national guidelines for the protection of children as set out in Children First. All staff members receive training in Children First as part of induction training.

Two child protection notifications were made over the previous year. While both were assessed, in one case a finding was made eight months after the incident, and the other case had not been concluded a year later.

Inspectors urge that child protection assessments are brought to a conclusion as soon as possible. In the absence of this staff are left feeling anxious and vulnerable to complaints. Equally when young people are awaiting feed back on the findings that were reached they can assume nothing is happening, thereby loosing confidence in child protection procedures.

**Recommendation:**

The board should ensure that child protection assessments are concluded as speedily as possible.

**4.8 Education**

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

Crannog Nua provides an on-site Special National School under the administration of the primary section of the Department of Education and Science. The school has an administrative principal and, up until recently had four whole time teachers. In August 2003, the principal was informed that the fourth temporary whole time teaching post was withdrawn.

Social workers and parents consistently commented on the progress the young people had made in school. Individual educational plans are devised for each of the young people. These plans are informed by previous educational attainment and experiences, and are also based on a six week assessment carried out by teaching staff. A varied curriculum is provided including English, Maths, Science, Art, Irish Studies, P.E, History, Geography, Computers, Civic, Social and Political Education (CSPE), and Social, Personal Health Education (SPHE).

While the on-site school is provided, if appropriate, young people can attend schools in the community. Equally not all of the pupils are residents of Crannog Nua. One day pupil who was resident in another residential unit attended during 2002. Three other young people, in the care of the health board, started on a day-pupil basis in September 2003. These young people were accompanied by care staff from the centres in which they lived. Inspectors consider that this was a very useful facility particularly for young people that have had difficulty attending or sustaining main stream schooling.

Each day is structured into six forty-minute classes. A hand over between care staff and teaching staff takes place before school begins. Homework is provided each week night. Three of the young people were completing the second level curriculum, one of whom recently received very successful Junior Certificate results. A fourth young person was starting the Junior Certificate Schools Programme. The fifth young person had been placed in another unit before commencing the school programme in Crannog Nua..

Behaviour management in school is enhanced by the fact that the school day is structured and the young people know what each day will entail. If young people leave the school of their own volition, the emphasis is on resolving the issue that caused them to leave, and on returning them to school as soon as possible. A 'student of the week' competition with a prize of 10 euro for the winner rewards positive behaviour and effort.

Each young person has a link teacher who liases with the young person's key worker. The school principal attends management meetings and placement review meetings accompanied by the young person's link teacher. On occasion the school principal attends the care staff team meeting.

The policy and procedures document states that the care staff are an integral part of the school team. Inspectors consider that greater integration could be developed between the school staff and the care staff towards the development of a more multi-disciplinary working environment. Further thought should be given to developing the role of the link teacher and key worker and the attendance of a member of the school staff at the weekly staff meeting where interventions and practice could be shared in an informed and focussed manner.

#### **4.9 Health**

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

The young people receive a medical assessment as soon as possible after admission to the unit. All of the young people have access to the unit's general practitioner and a female GP is available on request.

The young people receive medical, dental and other specialist services as required. Care records contain medical treatment consent forms and a record of medication administered and medical visits.

The unit operates a non-smoking policy. Guidance in relation to sex education and relationships is provided as part of the Social, Personal and Health Education (SPHE) programme in school.

Inspectors learned of one occasion where the unit was not able to access a doctor during out-of-hours after a young person had returned to the unit following an unauthorised absence. The details of this incident should be discussed with the unit's G.P. so that a similar situation does not occur.

While the general practitioner had no concerns about the primary care of the young people, inspectors were informed that there was a reticence to share information about the young people, including relevant details of their social history or past traumas with the general practitioner. Clarity is required about the type of information the G.P. requires about the young people to enable him to offer optimum care and to inform his approach to the young people.

**Recommendation:**

The director should clarify the type of information required by the general practitioner to inform his approach to and treatment of the young people and the medical service available to the unit during out-of-hours.

**4.10 Premises and safety**

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

*4.10.1 Accommodation*

Crannog Nua HSU is comprised of six buildings – an administration block; three residential units; a school and a sports block. They are purpose built single storey buildings.

Each residential unit is comprised of an entrance lobby; a large living and dining room area; two smaller sitting rooms, one of which was used for visitors and the other as a ‘quiet’ room; a kitchen and two adjoining staff offices. Each of the young people have their own bedroom with ensuite facilities.

Prior to the inspection field work all of the young people had been accommodated in one of the residential units. Inspectors were informed that in more settled times the rooms in this unit had been well furnished, creating a homely atmosphere and festive seasons were celebrated with appropriate decorations. However at the time of inspection furnishings were sparse. Inspectors were informed that certain pieces of equipment such as the TV, stereo and some board games had been removed from the main sitting room to the quiet room for safety reasons. While the visitor’s room was normally equipped with settees and a TV/DVD, these had also been removed as a temporary measure and replaced with two beanbags. The quiet room had an attractive mural that had been painted by three young people and one of the care staff and this room also contained photographs of the young people and staff. The two other units had only recently been opened to facilitate the separation of the three residents into the three accommodation units.

*4.10.2 Safety (including fire safety)*

The unit has a health and safety statement. A health and safety audit was carried out in September 2002. The majority of hazards have been addressed. However a small number of hazards have not been addressed such as the provision of training in de-escalation /breakaway techniques for ancillary staff; the provision of warning signs and a rubber mat for the electrical intake room in the administration unit; and the provision of training in the use of the school kiln.

Five members of staff are designated health and safety officers and share responsibility for different units on campus. Three of these staff members received a four day training programme in health and safety. First aid training is covered as part of the staff induction programme for all staff.

Inspectors noted a panel of glass in one of the units that has shattered following an incident with one young person. An on-going safety issue that has been difficult for the unit to resolve concerns the type of glass used in the unit. The glass in the fire door panels complies with fire safety regulations. However it also shatters and can break into shards when kicked by young people. Replacing it with other 'anti-bandit' glass does not however comply with fire regulations. The unit has sought the direction of the board's technical services section as to the most appropriate options available to them. At the time of inspection this issue has not been resolved.

Inspectors were informed that the shower jets in the young people's en-suite facilities cause the whole floor in the toilet area to become wet which constitutes a slip hazard and can leak out onto the carpet in the bedroom area. In one unit it was also pointed out to inspectors that while there were two washing machines and two dryers, staff could only use one washing machine and one dryer at a time or the system would fuse. These safety issues need to be addressed.

The units are equipped with an automatic fire alarm system, fire extinguishers, and smoke detectors, all of which are maintained. Fire drills have taken place on two occasions in the previous year.

The unit had a fire certificate and was insured for public and employers liability and for fire and associated risks.

### **Recommendations:**

The board should ensure that the issue in relation to the glass used in the fire doors is resolved.

The board should ensure that all outstanding health and safety issues are addressed.

## **5. *Summary of Recommendations***

- 1) The board should ensure that the purpose and function of Crannog Nua is reviewed to more accurately reflect the identified needs of young people requiring High Support and the unit's capacity to provide a service for them.
- 2) The board should ensure that a meeting of the Management Advisory Committee takes place as soon as possible.
- 3) The board should ensure that any outstanding IR issues are addressed and the board's position communicated to staff.
- 4) The board should ensure that the operational strategy for Crannog Nua is reviewed.
- 5) The director should ensure that a programme of regular supervision takes place and that all staff are facilitated to attend a weekly staff meeting.
- 6) The director should ensure that the register is amended to include all details required by regulation.
- 7) The board should ensure that a schedule of monitoring visits is devised to ensure that the requirements of each of the relevant standards are complied with. A format for reporting on an interim basis to the ACEO and the management and advisory committee should be agreed.
- 8) The director should ensure that the unit's policy and procedures document is revised to include the right of young people to access all information recorded about them and how this right should inform practice; and to provide a separate section on a young people's complaints procedure that reflects actual practice.
- 9) The board should ensure that the referral procedure is reviewed.
- 10) Principal Social Workers should ensure that statutory review meetings take place at intervals required by regulation. Care plans should be updated following review.
- 11) The director should ensure that practice in relation to young people's access to significant others in the community is continually monitored.
- 12) The role and responsibilities of the MST should be reviewed towards the development of a more integrated model of care.
- 13) The board should review the circumstances relating to the transfer/discharge of three of the young people.
- 14) The director should ensure that a review of the children's care files takes place.
- 15) The board should ensure that Crannog Nua's response to challenging behaviour is critically evaluated.
- 16) The board should ensure that child protection assessments are concluded as speedily as possible.
- 17) The director should clarify the type of information required by the general practitioner to inform his approach to and treatment of the young people and the medical service available to the unit during out-of-hours.
- 18) The board should ensure that the issue in relation to the glass used in the fire doors is resolved.
- 19) The board should ensure that all outstanding health and safety issues are addressed.